SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST

Benefits Enrollment / Change Form for DCU Early Retirees

For HR/Benefits use only
Coverage effective date _____
MONTH / DAY/ YEAR
❒ DP ❒ SP

Reason for Enrollment

❒ Open Enrollment ❒ New Hire ❒ Change in Status*

Date of Change _____ Reason _____

❒Enrolled in public healthcare exchange effective _____, 20____.

*Change in status is allowed for qualifying life events, which include but are not limited to:
- Marriage
- Divorce or legal separation
- Birth, adoption or legal guardianship
- Death
- Gain or loss of other coverage
- Full-time or part-time status change

You will be asked to provide documentation for these events. Find details at **http://sdtrust.com/benefits-whatif.html**.

Early Retiree Information

(All fields are required)

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NO.

HOME ADDRESS	EMPLOYEE ID NO.
CITY, STATE, ZIP	E-MAIL ADDRESS

HOME PHONE	DATE OF BIRTH	MARITAL STATUS	GENDER
		❒ SINGLE ❒ MARRIED ❒ DIVORCED	❒ MALE ❒ FEMALE

Medical, Dental and Vision Plans

You must choose one.

Early Retiree Medical Plans	GROUP #		GROUP #
❒ Early Retiree Providence Open Option	R009	❒ Early Retiree Kaiser	1740-008
❒ Early Retiree Providence Personal Option	R008		

Trust Dental/Vision Plans (available only if you're enrolled in a medical plan, unless you defer/suspend medical coverage)

❒ Basic Trust Dental/Vision (Kaiser participants will only receive Trust dental coverage, vision is included with Kaiser medical)

❒ Buy-Up Trust Dental/Vision (Kaiser participants will only receive Trust dental coverage, vision is included with Kaiser medical)

Dependent Information

If you are adding or dropping a dependent, complete the following section. To maintain your current dependents, check the box below.

❒ MAINTAIN CURRENT DEPENDENTS (If enrolling in a new medical plan, dependent's information must be provided)

Spouse/Domestic Partner

ACTION	LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NO. (REQUIRED)*	DATE OF BIRTH	GENDER	RELATIONSHIP
❒ ADD ❒ DROP						❒ MALE ❒ FEMALE	❒ SPOUSE ❒ DOMESTIC PARTNER

Children – If you need to enroll additional dependents please fill out and attach a second, signed enrollment form that lists them.

ACTION	LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NO. (REQUIRED)*	GENDER	BIRTHDATE MM/DD/YY	RELATIONSHIP: NATURAL/ ADOPTED/STEPCHILD	EMPLOYEE RESPONSIBLE FOR SUPPORT?	INCAPACITATED CHILD?
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO
❒ ADD ❒ DROP					❒ MALE ❒ FEMALE			❒ YES ❒ NO	❒ YES ❒ NO

* Dependents will not be added if a social security number is not provided for that dependent.

You must inform the Trust if a dependent spouse, domestic partner or child is no longer eligible to receive benefits from the Trust. Please be aware if an individual who has been reported as your dependent receives benefits after Trust eligibility has ended, the Trust may recover the improperly-paid benefits from you.

Other Coverage

If you, your spouse/domestic partner or other dependents are covered by District coverage or by any other health care insurance, complete the following section;

Is your spouse/domestic partner also an employee of the School District?	❒ Yes ❒ No
Are you or any family member(s) covered by:	❒ Medicare ❒ Other coverage If yes, check the types of coverage ❒ Medical ❒ Dental ❒ Vision Complete the "Family Members Covered Under Other Coverage" section below.

Early Retiree Information

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.

Child Custody Information

If you or your spouse are divorced or legally separated, please indicate who has custody of your child(ren).	❒ Self ❒ Spouse ❒ Other
Has the parent without custody been mandated by court decree to provide coverage for the dependent child(ren)?	❒ Yes If yes, complete the "Family Members Covered Under Other Coverage" section below. ❒ No

Family Members Covered Under Other Coverage

To be completed only if you, or a dependent you are enrolling through the Trust, has other insurance.

NAME OF FAMILY MEMBER WITH OTHER COVERAGE	DATE OF BIRTH	NAME OF OTHER INSURANCE PLAN
NAME OF EMPLOYEE	GROUP ID NUMBER	EFFECTIVE DATE OF COVERAGE
CLAIMS ADDRESS		

Medicare Eligibility

Completion of this information is required.

Name	Enrolled in Medicare? (If Yes, you must send copy of Medicare Card) Part A	Part B	Check Box if Applicable	Date Dialysis Began or Date of Transplant (MM/DD/YY)
SELF	❒ Yes ❒ No	❒ Yes ❒ No	❒ Dialysis ❒ Kidney Transplant	
SPOUSE/DOMESTIC PARTNER	❒ Yes ❒ No	❒ Yes ❒ No	❒ Dialysis ❒ Kidney Transplant	
DEPENDENT	❒ Yes ❒ No	❒ Yes ❒ No	❒ Dialysis ❒ Kidney Transplant	
DEPENDENT	❒ Yes ❒ No	❒ Yes ❒ No	❒ Dialysis ❒ Kidney Transplant	
DEPENDENT	❒ Yes ❒ No	❒ Yes ❒ No	❒ Dialysis ❒ Kidney Transplant	

Signature

My signature below indicates that I have read and understand this enrollment form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified except as explained in the descriptive materials provided. I authorize my insurance carriers to obtain, examine, or release any medical or dental records or other information needed to coordinate benefits or process claims for me and my family members. I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers any medical information it requests. I authorize my insurance carriers to share such medical information with me or my dependents' health care providers. I declare that the dependents listed on this form are my eligible dependents. I also declare that the information furnished on this form is correct and complete to the best of my knowledge.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL _____ DATE _____

Return completed form to:
Trust Office, 700 NE Multnomah St., Suite 350 Portland, OR 97232