SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST Benefits Enrollment / Change Form for PFSP Early Retirees

For HR/Benefi Coverage effe	,	
□ DP □ SP)	MONTH / DAY/ YEAR

Reason for Enrollme	ent												
□ 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 • Full-time or part-time status change You will be asked to provide documentation for these events. Find details at http://sdrtust.com/benefits-whatif.html.							
Early Retiree Inform (All fields are required)	ation												
LAST NAME		FIRST					SOCIAL SECURITY NO.						
HOME ADDRESS						EMPLOYEE ID NO.							
CITY, STATE, ZIP									E-MAIL ADDRESS				
HOME PHONE					marital sta					gender MAL	.E 🗖	FEMALE	
Medical, Dental and You must choose one.	Vision P	lans											
Early Retiree Medical Plans GROUP #									GROUP #				
☐ Early Retiree Providence Open C	Option	R00 <i>6</i>	ó		☐ Early Re	tiree Kaiser			1740-007				
☐ Early Retiree Providence Persona	ıl Option	R005											
Trust Dental/Vision Plans (av	vailable only if	you're enro	olled in a	a medi	cal plan, ı	ınless you	defer/s	uspend i	medical coverd	age)			
☐ Basic Trust Dental/Vision (Kaise	r participants wi	ill only rec	eive Trus	st denta	al coverage	e, vision is	include	d with K	aiser medical)	-			
☐ Buy-Up Trust Dental/Vision (Kai	ser participants	will only r	eceive 1	Trust de	ental cover	rage, visio	n is incl	uded wit	th Kaiser medic	cal)			
Dependent Informat If you are adding or dropping		, complet	e the fo	ollowir	ng section	n. To mai	ntain y	our cur	rent depende	ents, ch	eck the	e box l	below.
☐ MAINTAIN CURRENT DEPENDENTS (If er	nrolling in a new med	dical plan, de _l	oendent's ir	nformatic	on must be pro	ovided)							
Spouse/Domestic Partner													
	FIRST	II.	IITIAL	SOCIA	AL SECURITY 1	NO. (REQUIRED)*		DATE OF BIRTH		GENDER		RELATIONSHIP	
□ ADD □ DROP										☐ MALE ☐ FEMA		☐ SPOU	JSE NESTIC PARTNER
Children – If you need to enroll ad	ditional depend	lents pleas	e fill out	t and a	ıttach a sec	cond, sign	ed enro	Ilment fo	orm that lists th	em.			
ACTION LAST NAME F	FIRST	INITIAL	SOCIAL (REQUIF	al Security no.		GENDER	BIRTHD MM/DI				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 secu	rity number is not pro	ovided for that	depender	nt.									

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 I	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?	T T T T T T T T T T T T T T T T T T T
Are you or any family member(s) covered by:	☐ Medicare ☐ Other coverage
	If yes, check the types of coverage

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).										
Has the parent without custody been mandated by court decree to provide coverag for the dependent child(ren)?				☐ Yes If yes, complete the "Family Members Covered Under Other Coverage" section below. ☐ No						
Family Members Covered Under (To be completed only if you, or a dependent you are enro			ther insu	ırance.						
NAME OF FAMILY MEMBER WITH OTHER COVERAGE			TH	N	AME OF OTHER INSURANCE PLAN					
NAME OF EMPLOYEE	AME OF EMPLOYEE			EF	FFECTIVE DATE OF COVERAGE					
CLAIMS ADDRESS										
Medicare Eligibility Completion of this information is required.										
	Enrolled in (If Yes, you mu Medica	of				Date Dialysis Began or Date of Transplant				
Name	Part A Part		В	Che	eck Box if Applicable		(MM/DD/YY)			
SELF	☐ Yes ☐ No	☐ Yes	□ No	□ Dialysis	□ Kidney T	ransplant				
SPOUSE/DOMESTIC PARTNER	☐ Yes ☐ No	☐ Yes	□ No	□ Dialysis	☐ Kidney T	ransplant				
DEPENDENT	☐ Yes ☐ No	☐ Yes	□ No	□ Dialysis	☐ Kidney T	ransplant				
DEPENDENT	☐ Yes ☐ No	☐ Yes	□ No	□ Dialysis	s □ Kidney T	ransplant				
DEPENDENT	☐ Yes ☐ No	☐ Yes	□ No	□ Dialysis	s □ Kidney T	ransplant				
Signature										
My signature below indicates that I have read and unders and cannot be revoked or modified except as explained in any medical or dental records or other information needed provider having knowledge of my medical history or my dinsurance carriers to share such medical information with eligible dependents. I also declare that the information fur	n the descriptive n ed to coordinate b ependents to rele me or my depend	naterials pro enefits or pr ase to my in lents' health	ovided. I rocess classifications surance n care pr	authorize naims for me carriers an oviders. I d	ny insurance co e and my family y medical infor eclare that the	rriers to obta members. I mation it requ dependents li	in, examine, or release also authorize any uests. I authorize my			

Return completed form to:

Trust Office, 700 NE Multnomah St., Suite 350 Portland, OR 97232