HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

For HR/Benefits use only
Coverage effective date:

____

Benefits Enrollment / Change Form
ATU Type 10 Driver Employees

REASON FOR ENROLLMENT

❑ New Hire ❑ Change in Status* ❑ Bi-Annual Enrollment

Change in Status:* Date: 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/Domestic Partnership
- 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 **sdtrust.com**

EMPLOYEE INFORMATION (All fields are required)

Last Name: First: Initial: Employee ID No.:

Employment Status: ❑ Full-time ❑ Part-time Date of Birth:

Home Address: City/State/Zip:

E-mail Address: Home Phone:

Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Divorced Gender: ❑ Male ❑ Female

MEDICAL AND DENTAL PLANS (You must choose one or check here ❑ to decline coverage.)

MEDICAL PLAN	PROVIDER NETWORK	DENTAL PLAN (You must be enrolled in a medical plan to enroll in dental.)	PROVIDER NETWORK
❑ Providence PPO	Providence PPS/SD-1 Trust	❑ Kaiser Permanente Dental	Kaiser Permanente
❑ Kaiser Permanente	Kaiser Permanente	❑ Trust Dental	Delta Dental of OR
❑ Providence In-Network Only	Providence PPS/SD-1 Trust		

DEPENDENT INFORMATION

Please provide the information requested for each dependent you are adding or dropping from enrollment. Dependent eligibility will be verified.

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 add or drop 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	DATE OF BIRTH	RELATIONSHIP	EMPLOYEE REPONSIBLE FOR SUPPORT?	INCAPACITATED CHILD?
❑ ADD ❑ DROP					❑ MALE ❑ FEMALE		❑ NATURAL ❑ ADOPTED ❑ STEPCHILD ❑ LEG. GUARDIAN	❑ YES ❑ NO	❑ YES ❑ NO
❑ ADD ❑ DROP					❑ MALE ❑ FEMALE		❑ NATURAL ❑ ADOPTED ❑ STEPCHILD ❑ LEG. GUARDIAN	❑ YES ❑ NO	❑ YES ❑ NO
❑ ADD ❑ DROP					❑ MALE ❑ FEMALE		❑ NATURAL ❑ ADOPTED ❑ STEPCHILD ❑ LEG. GUARDIAN	❑ YES ❑ NO	❑ YES ❑ NO

* If you are enrolling a domestic partner for the first time, you must submit a signed, notarized Affidavit of Domestic Partnership or Multnomah County Certificate of Domestic Partnership.
** Dependents will not be added if a social security number is not provided for that dependent.

Dependent eligibility will be verified upon enrollment. 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 that if an individual who has been reported as your dependent receives benefits after Trust eligibility has ended, the Trust or provider may recover the improperly paid benefits from you.

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HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

EMPLOYEE INFORMATION

Last Name: First: Employee ID No.:

OTHER COVERAGE

If you, your spouse/domestic partner or other dependents are enrolled in their own coverage through the District or any other health care insurance, complete the following section:

st Name: First: Initial: Employee ID No.:

Is your spouse/domestic partner also an employee of the School District? ❑ Yes ❑ No

Are you or any family member(s) enrolled in: ❑ Medicare ❑ Other Coverage

If yes, check the types of coverage: ❑ Medical ❑ Dental ❑ Vision Complete the "Family Members Enrolled in Other Coverage" section below

FAMILY MEMBERS ENROLLED IN OTHER COVERAGE

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

Full Name of Family Member: Date of Birth:

Name of Insurance Plan:

Group ID Number: Effective Date of Coverage:

Claims Address:

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

DECLARATION TO DECLINE COVERAGE

I hereby decline coverage for Medical, Dental, and Vision through the School District No. 1 Health and Welfare Trust. I attest that I have other group health insurance coverage. I understand that I may not enroll in health coverage until the next open enrollment period, unless I notify PPS benefits within 31 days of qualified status change (QSC). For more information on QSC and how to change your benefits mid-year, visit: **sdtrust.com**, My Life Events.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL DATE

Submit the completed form to the PPS Benefits Department to be received by the deadline.

Email: **benefits@pps.net**
Fax: 503-916-3107

In person or by mail:
501 N. Dixon St., Suite 200
Portland, OR 97227