HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

For HR/Benefits use only ❑ DP
Coverage effective date: ❑ SP
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Benefits Enrollment / Change Form
DCU Early Retirees

REASON FOR ENROLLMENT

❑ Open Enrollment ❑ Change in Status*

Date of Change: Reason:

❑ Enrolled in public healthcare exchange effective: , 2022

*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

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.:

Social Security No.: Date of Birth:

Home Address: City/State/Zip:

E-mail Address: Home Phone:

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

MEDICAL, OPTIONAL VISION AND DENTAL PLANS

MEDICAL (Choose one)	OPTIONAL, SELF-PAY DENTAL & VISION (Choose one—you must also enroll in a medical plan)*
❑ Early Retiree Kaiser Permanente (Includes vision)	❑ Kaiser Basic Dental Plan ❑ Kaiser Buy-up Dental Plan ❑ Trust Basic Dental Plan (Delta Dental of Oregon) ❑ Trust Buy-Up Dental Plan (Delta Dental of Oregon)
❑ Providence PDA PPO Retiree ❑ Providence PDA Retiree In-Network Only	❑ Kaiser Basic Dental Plan / Trust Basic Vision Plan (VSP) ❑ Trust Basic Dental Plan (Delta Dental of Oregon) / Trust Basic Vision Plan (VSP) ❑ Kaiser Buy-up Dental Plan / Trust Buy-up Vision Plan (VSP) ❑ Trust Buy-Up Dental Plan (Delta Dental of Oregon) / Trust Buy-up Vision Plan (VSP)

*Your dental enrollment choice cannot be changed after your initial enrollment in Early Retiree benefits.

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

* 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. If you do not inform the Trust and your enrolled dependent(s) receive benefits after Trust eligibility has ended, the Trust may recover the improperly-paid benefits from you.

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SCHOOL DISTRICT NO.1

EARLY RETIREE INFORMATION

Last Name: First: Initial: 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:

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.

CHILD CUSTODY INFORMATION

If you and 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 ❑ No If yes, 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:

MEDICARE ELIGIBILITY Completion of this information is required.

NAME	ENROLLED IN MEDICARE? (If Yes, you must send copy of Medicare Card)		CHECK BOX IF APPLICABLE	DATE DIALYSIS BEGAN OR DATE OF TRANSPLANT (MM/DD/YY)
	PART A	PART B		
SELF	❑ YES ❑ NO	❑ YES ❑ NO	❑ DIALYSIS ❑ KIDNEY TRANSPLANT ❑ ALS	
SPOUSE/DOMESTIC PARTNER	❑ YES ❑ NO	❑ YES ❑ NO	❑ DIALYSIS ❑ KIDNEY TRANSPLANT ❑ ALS	
DEPENDENT	❑ YES ❑ NO	❑ YES ❑ NO	❑ DIALYSIS ❑ KIDNEY TRANSPLANT ❑ ALS	
DEPENDENT	❑ YES ❑ NO	❑ YES ❑ NO	❑ DIALYSIS ❑ KIDNEY TRANSPLANT ❑ ALS	
DEPENDENT	❑ YES ❑ NO	❑ YES ❑ NO	❑ DIALYSIS ❑ KIDNEY TRANSPLANT ❑ ALS	

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 by mail or fax to:
Trust Administrative Office
12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
Fax: 971-239-0672