SBCCOE

Medical • Dental • Vision • Life Enrollment and Change Form

HR USE ONLY		
☐ NBAJOBS	☐ PDABDSU	☐ PDADEDN
☐ PDABENE	☐ PDABCOV	☐ FAX FORM

A. EMPLOYEE INFORMATION (Complete all information printing legibly. Missing, inaccurate or illegible information will be returned causing a delay in the application process).

Employee Last Name	Employee First Name	MI	Gender ☐ M ☐ F	Social Security Number - -

Home Address (address where you will receive member correspondence)	City	State	Zip Code

Institution Name	Medical Group Number (Required)	Dental Group Number (Required)

Home Phone Number	Office Phone Number	Date of Hire / /	Effective Date or Date of Qualifying Event / /

B. CHANGES ONLY (Complete for changes to existing medical/dental coverage).

Additions		Deletions		Cancel Employee Coverage	
Person(s)	Reason	Person(s)	Reason		☐ Name Change, Previous Name
☐ Spouse ☐ Domestic Partner ☐ Child(ren)	☐ Adoption ☐ Birth ☐ Marriage ☐ Open Enrollment ☐ Other____________	☐ Spouse ☐ Domestic Partner ☐ Child(ren)	☐ Birth ☐ Medicare/Medicaid ☐ Death ☐ Open Enrollment ☐ Dependent Child Ineligible ☐ Divorce ☐ Other______________________	☐ Medical ☐ Dental ☐ Vision ☐ Life	☐ Beneficiary Change ☐ Address/Telephone Change

C. COVERAGE DESIRED

Medical Plan Coverage		Dental Plan Coverage		Vision Plan Coverage (VSP)
☐ BlueAdvantage HMO ☐ BlueAdvantage HMO Point-of-Service ☐ BluePreferred Plan* ☐ Kaiser Permanente	☐ Employee Only ☐ Employee+Family ☐ Decline	☐ Delta Dental Option I ☐ Delta Dental Option II	☐ Employee Only ☐ Employee+Family ☐ Decline	☐ Employee Only ☐ Employee+One ☐ Employee+Family ☐ Decline

***COMPLETE THIS SECTION IF YOU ARE ENROLLING IN THE BLUEPREFERRED PLAN**

An individual may qualify for a waiver of the pre-existing condition waiting period as stated on the back of this application, if the individual has had other medical coverage within the last 90 days. Have you had any medical plan coverage in the last 90 days? ☐ Yes ☐ No
If yes, attach a copy of your Certificate of Creditable Coverage, if available, or other evidence of coverage (Copy of ID Card(s) does not qualify as evidence). If No, the individual will be subject to a pre-existing condition waiting period of up to 6 months, unless the individual is applying for coverage within 30 days of eligibility. This exclusion does not apply to members under age 19.

D. LIST OF ELIGIBLE DEPENDENTS (List self and all eligible dependents including your spouse/domestic partner you wish to cover. Use a separate sheet if needed).

I	Name (Last, First, Middle Initial)	Social Security Number	Relationship	M/F	Date of Birth (MM/DD/YYYY)	Primary Care Provider Name MUST COMPLETE FOR HMO & HMO POS COVERAGE	Current Patient
			SELF				☐ Yes ☐ No
OTHER INSURANCE ☐ Yes ☐ No	COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Life						
II	**Name (Last, First, Middle Initial)**	**Social Security Number**	**Relationship**	**M/F**	**Date of Birth (MM/DD/YYYY)**	**Primary Care Provider Name MUST COMPLETE FOR HMO & HMO POS COVERAGE**	**Current Patient**
							☐ Yes ☐ No
OTHER INSURANCE ☐ Yes ☐ No	COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Life						
III	**Name (Last, First, Middle Initial)**	**Social Security Number**	**Relationship**	**M/F**	**Date of Birth (MM/DD/YYYY)**	**Primary Care Provider Name MUST COMPLETE FOR HMO & HMO POS COVERAGE)**	**Current Patient**
							☐ Yes ☐ No
OTHER INSURANCE ☐ Yes ☐ No	COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Life						
IV	**Name (Last, First, Middle Initial)**	**Social Security Number**	**Relationship**	**M/F**	**Date of Birth (MM/DD/YYYY)**	**Primary Care Provider Name** MUST COMPLETE FOR HMO & HMO POS COVERAGE	**Current Patient**
							☐ Yes ☐ No
OTHER INSURANCE ☐ Yes ☐ No	COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Life						

E. LIFE INSURANCE

BASIC TERM LIFE
☐ 1 X Annual contract rounded up the nearest $1,000 (minimum $50,000)*
☐ 2 X Annual contract rounded up the nearest $1,000 (maximum $300,000)*
☐ 3 X Annual contract rounded up the nearest $1,000 (maximum $300,000)*
☐ Decline

PRIMARY BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP
CONTINGENT BENEFICIARY NAME (Last, First, Middle Initial)	**RELATIONSHIP**

DEPENDENT TERM LIFE ☐ $5,000 ☐ $10,000 ☐ Decline

F. BEFORE OR AFTER TAX ELECTION

☐ I elect to reduce my gross wages and have all eligible medical, dental, term life and vision insurance premiums paid on my behalf with before tax dollars. Once elected, this before tax deduction(s) will continue each plan year until I sign a waiver. The waiver can only be signed during open enrollment or as the result of an eligible status or FMLA change. I understand that before tax premium payments cannot be applied toward a deduction on my federal tax return and that my PERA benefits may be affected by my before tax elections under this plan.

☐ I elect to pay my eligible premiums with after tax dollars.

I have read and understand the benefit choices available. I have read and understand the Pre-Existing Condition Exclusion, the Kaiser Permanente Terms and Conditions as well as Anthem Blue Cross and Blue Shield provisions on the back side of this form. I also understand that my elections for insurance coverage will continue unchanged each plan year until I complete and sign a new Enrollment and Change form. Election changes are only allowed during open enrollment or as is consistent under the plan rules.

EMPLOYEE SIGNATURE	DATE

*Benefits between ages 65-75 decrease, ask for the details

State Board for Community Colleges and Occupational Education (REV 04/11)

FORM NO. 98718 (4-11) Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

Anthem Blue Cross and Blue Shield and HMO Colorado Terms and Conditions

For more information about Anthem Blue Cross and Blue Shield, its products and services visit anthem.com.

The following applies to health plans coverage offered through Anthem Blue Cross and Blue Shield and HMO Colorado.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For individuals applying for BlueAdvantage HMO and BlueAdvantage Point-of-Service plan:

I have indicated the Primary Care Provider of my choice, on the front of this application. I understand that the services for which I and my dependents will be eligible, as described in the Certificate, must be obtained from the HMO Colorado Primary Care Provider I have selected.

There are no pre-existing condition waiting periods for BlueAdvantage HMO or BlueAdvantage Point-of-Service coverage.

For individuals applying for BluePreferred Plan:

Pre-existing condition waiting period - Anthem Blue Cross and Blue Shield will not pay for services related to a pre-existing condition for six consecutive months (6 months if a Late Entrant) after the member's original effective date, or if earlier, the first day of the waiting period.

"Pre-existing condition" is defined as any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such a plan or, if earlier, the first day of the waiting period for such enrollment. Anthem Blue Cross and Blue Shield will not impose any pre-existing condition exclusions to any member up to age 19, or relating to pregnancy.

NOTE: The pre-existing condition waiting period will be waived for anyone meeting the state-mandated definition of "creditable coverage" within the last 90 days prior to the effective date of our coverage. The period of continuous coverage shall not include any waiting period for the effective date of new coverage. The employee can obtain proof of prior coverage from the creditable coverage form required by Federal (HIPAA) law.

A 6-month pre-existing condition waiting period only applies to Anthem Blue Cross and Blue Shield members who are late entrants and have no prior creditable coverage for 90 days prior to their effective date. In determining the extent of the gap in coverage the current waiting period is excluded.

Kaiser Permanente Terms and Conditions

Conditions for Enrollment: I have read and agree to the terms and conditions of this enrollment form. Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in CRS 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

I expressly authorize my doctor or hospital to furnish Kaiser Permanente any records concerning me or any other member of my family.

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel membership and/or refuse to pay claims.

I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if Kaiser Permanente accepts this application, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.