



Butte Schools Self-Funded Program
Healthy Employees Supported by Quality Care
EMPLOYEE BENEFIT PLAN APPLICATION FORM

Additional info needed for school board members

Choose district/bargaining unit combo from drop-down list

SSN First Middle Last Birthdate Gender Marital
 Address City State Zip Phone Phone
 Hired Employee # Title Group Status Board

APPLICATION TYPE (check all that apply)

New enrollment at date of hire

Transfer from another BSSP district:

Dependent change. Complete box on right.
 Declination of coverage at initial eligibility date (part-time employees and school board members, only): I decline coverage at this time. I understand I may elect coverage only during a future BSSP open enrollment period (May 1-May 31, effective July 1) or within 31 days of a change in my total work hours or work year. Initial:

Dependent child or former spouse electing COBRA. Enter name of employee previously covered under below.

Name change. Enter former name below.

Surviving spouse. Enter spouse's name below.

Re-enrollment due to change in hours or work year

New address

Re-enrollment due to court order or loss of other coverage (attach documents)

Voluntary disenrollment: I understand that I may re-enroll in a BSSP plan only at the time of a change in my total work hours or work year. Initial:

DEPENDENT CHANGE (indicate changes under Dependent(s) below.)

Add child at birth. Add child due to other qualifying event. List event/date:

Add spouse/registered domestic partner Delete dependent (enter reason in box on right)

COORDINATION OF BENEFITS (COB) applies only to full-time employees and active school board members with a spouse/RDP. Can you (individual or family) through his/her employer for a payroll deduction of less than \$125 per month if your spouse is self-employed or is not employed. Answer "Yes" if your spouse elects a cash-in-lieu of coverage for less than \$125 per month instead. Dental and vision coverages are excluded from this plan.

No. Obtain your Spouse's/RDP's Employer's Certification I: Cost of Employee-Only Coverage on the reverse of this sheet.

Yes, select option A or B:

A My spouse/RDP is enrolled (or will enroll at his/her next open enrollment) in a plan through his/her employer. If your spouse/RDP is also covered as an employee under a BSSP plan, initial here . If your spouse/RDP is covered with another carrier, obtain your Spouse's/RDP's Employer's Certification II: Employer Coverage on the reverse of this sheet. This policy requires employer coverage for your spouse/RDP, only. By law, your spouse/RDP's employer coverage is his/her primary coverage. Because BSSP medical plans do not provide pharmacy benefits for secondary coverage, his/her employer plan will be his/her only pharmacy coverage. If his/her coverage has no pharmacy benefit, attach documentation from the employer/carrier indicating no pharmacy benefits are provided under his/her plan.

B Enroll my spouse/RDP in BSSP JPA's Phantom Coordination of Benefits (PCOB) plan. Under the PCOB plan, s/he will be responsible for co-pays (\$25 office/ \$100 ER / \$250 in-patient), a \$500 deductible and 80% co-insurance payments. There is no maximum limit to her/his out-of-pocket responsibility. Her/his prescription benefits will be provided at the same level as my BSSP plan.

Do not process form w/o initials here IF this box is selected.

ELECTED COVERAGE

Dental Life If yes, complete separate enrollment form for life coverages and input optional amounts below.

Medical Vision Optional Employee Optional Spouse Optional Dependent (birth to age 25) Yes No

DEPENDENT(S): Application for dependents must be submitted within 31 days of dependent's eligibility date. See the reverse for a summary of eligible dependents and dates of eligibility. A copy of your marriage/registered domestic partnership certificate and/or child's birth certificate, adoption papers, etc. must be received by your employer within 90 days of your dependent's eligibility date.

Add / Drop	Relationship	Gender	Last, First MI	Date of Birth	Certificate attached?	Social Security #	Coverage		
<input type="checkbox"/>							<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
<input type="checkbox"/>							<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
<input type="checkbox"/>							<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
<input type="checkbox"/>							<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
<input type="checkbox"/>							<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision

Select plan or decline

PLEASE READ CAREFULLY

- Authorization to obtain or release medical information: Butte Schools Self-Funded Programs (BSSP) is authorized to obtain and release medical information in compliance with HIPAA and any other insurance and privacy protection act.
- I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of Anthem Blue Cross, Delta Dental, VSP, Medco or BSSP any and all records of medical history, services rendered, or for purpose of review, reimbursement or added hereafter.
- I authorize BSSP or its agent to disclose to the insurer or self-insurer or insurer necessary to allow the insurer to process claims and establish rates.
- This authorization shall remain in effect as long as necessary to enable BSSP to process claims and establish rates.

I understand I am responsible for a greater portion of my medical costs when I use a non-participating provider.

I understand any dispute between myself (and/or enrolled family member) and Anthem Blue Cross, Delta Dental, VSP, Medco or any affiliate, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the small claims court and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage the member and Anthem Blue Cross, Delta Dental or VSP are giving up the right to have any dispute decided in a court of law before a jury.

UNDER PENALTY OF PERJURY AND THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT. I WILL REPAY ANY AMOUNTS PAID FRAUDULENTLY ON BEHALF OF MYSELF, MY SPOUSE/PARTNER AND/OR MY DEPENDENT CHILDREN.

Date

Be sure to complete this info on COBRA enrollments.

District to enter effective date

District to verify/correct amounts requested by EE

Need this info on ALL retirees

Information below this is liability of District HR/Payroll Staff

HIPPA/COBRA Date

All coverages effective

Notes, Signature

Circle One:
 Reduction in hours / days
 Termination Death
 Divorce/legal separation
 No longer a dependent

Optional EE Life

Optional SP Life

District-paid retiree medical? Yes No

**Spouse's/RDP's Employer's Certification I:
Cost of Employee-Only Coverage
(Required when you answer "No" to Coordination of Benefits question on the reverse.)**

This certification must be completed by your spouse's/registered domestic partner's employer if you answered "No" to Part I on the reverse of this sheet.

- A. BSSP Covered Member: _____
- B. BSSP Covered Member's Spouse/Registered Domestic Partner _____

I hereby certify that the person listed in line B, above, is not eligible and/or does not have the option of purchasing medical (employee-only or composite) coverage through his/her employer at a cost of less than \$125 per month.

Employer: _____ Signature: _____
By: _____ Date: _____
(printed name)

**Spouse's/RDP's Employer's Certification II:
Employer Coverage
(Required when you select option "A" in the Coordination of Benefits section on the reverse.)**

This certification must be completed by your spouse's/registered domestic partner's employer if you selected option "A" on the reverse of this sheet. This form certification is not required if your spouse/RDP is also covered as an employee under a BSSP plan.

- A. BSSP Covered Member: _____
- B. BSSP Covered Member's Spouse/Registered Domestic Partner _____

I hereby certify that the person listed in line B, above, is covered under his/her employer's medical and prescription benefit plan effective _____; carrier: _____; carrier address: _____
_____; employee benefit ID number: _____.

Employer: _____ Signature: _____
By: _____ Date: _____
(printed name)

Dependent Eligibility

A dependent becomes eligible for coverage on the later of: (a) the date the employee becomes eligible for coverage; or (b) the date the dependent qualifies as such under Butte Schools Self-Funded Programs Policy and Procedure 1.4:

- A. The following are eligible to enroll as dependents:
1. The employee's spouse or registered domestic partner; and
 2. An unmarried child.
- B. Definition of Dependents
1. Spouse is the employee's spouse as recognized by any state. Spouse does not include any person who is in active service in the armed forces.
 2. Registered domestic partner is an individual who has filed, along with the employee, a Declaration of Domestic Partnership with the State of California, or a similar declaration issued by another state.
 3. Child is the employee's, spouse's or registered domestic partner's natural child, stepchild, or legally adopted child, subject to the following:
 - a. The child is under 26 years of age. Coverage will terminate on the last day of the month in which the child turns age 26.
 - b. The child is 26 years of age, or more and: (i) was covered under the prior plan, or has six or more months of creditable coverage, (ii) is chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. The certification must be received, at no expense, within 60-days of the date the employee receives the request. BSSP may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
 - c. A child who is in the process of being adopted is considered a legally adopted child if the district receives legal evidence of: (i) the intent to adopt; and (ii) the employee's, spouse's or registered domestic partner's: (a) right to control the health care of the child; or (b) assumption of a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee's, the spouse's or the registered domestic partner the right to control the health care of the child.

Exception. A foster child is not covered unless BSSP receives legal evidence of (a) the intent to adopt issued by the court and (b) the employee, spouse or registered domestic partner's assumption of a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.