KETTERING CITY SCHOOLS

INSURANCE APPLICATION

CIRCLE ALL THAT APPLIES

NEW ENROLLMENT	YES	
CANCEL INSURANCE	YES	INSURANCE EFFECTIVE DATE
ADD DEPENDENT	YES	
CANCEL DEPENDENT	YES	DATE EMPLOYED
NAME CHANGE	YES	

(A) EMPLOYEE INFORMATION Name		MEDICAL	DENTAL	WAIVE ALL
Address		YES / NO	YES / NO	INELIGIBLE
Social Security number				
Date of Birth	Gender: M / F			
Marital Status (Circle one)	Single Married Divorced Widowed			
(B) FAMILY INFORMATION Spouse		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				

IF MORE DEPENDENTS, PLEASE WRITE INFORMATION ON ANOTHER SHEET OF PAPER AND ATTACH

(C) THIS SECTION MUST BE COMPLETED IF YOU HAVE OTHER MEDICAL INSURANCE

Do you or any dependents have other health coverage?		YES	NO
If yes, provide information			
Name of Policy Holder	Name of other Insurance Co	Policy #	Policy Type (single, etc)
Are you covered by Medicare?		YES	NO
Are your spouse and/or dependents covered by Medicare?		YES	NO
If enrolled in Medicare, please attach a copy of Medicare ID card(s)			

(D) LIFE INSURANCE BENEFICIARY'S NAME(S) (Please print) Group Policy# 5479448 — Annual Salary: $

Last Name	First Name	Middle Initial	Relationship to Employee	%
Last Name	First Name	Middle Initial	Relationship to Employee	%

I confirm that the information I have provided on this form is complete and accurate.

(Employee Signature) Date

PART I - Dependent Enrollment Affidavit

Please present the following documents to your District Treasurer's or HR Office:

Spouse:

- Marriage certificate **AND**
- Front page of the most recent federally filed tax return.

For Each Child:

- Each child's birth certificate naming the employee/spouse as the child's parent ***OR***
- Adoption papers naming the employee/spouse as the child's adoptive parent ***OR***
- Appropriate court documents naming the employee/spouse as the child's legal guardian.

Part II – Completion by HR/Treasurer Department

Please upload this affidavit and all required document(s) into staff member's file cabinet in Benelogic.

	Spouse		Children		
Dependent Name	Marriage Certificate	Recent Tax Form	Birth Cert	Adoption	Legal Guardianship

I have certified that all of the above has been reviewed and the dependents are eligible under the group benefit plan.

Signature of District HR/Treasurer's Department: _____

District: KETTERING CITY SCHOOL DISTRICT **Date:** _____

By my signature on this form, I certify and warrant to my employer that all information submitted is true, correct and current as of the date signed and any attempt to enroll for /or maintain coverage for an ineligible dependent will be subject to appropriate disciplinary action. I have provided the documentation for each eligible dependent as required. I understand I will be responsible for any claim payments made for ineligible dependents.

Signature of Employee (REQUIRED): _____ **Date:** _____

Dependent Enrollment Procedures 2017-2018

*This form and appropriate documentation **MUST BE SUBMITTED DURING THE ELIGIBILITY PERIOD** before coverage will be effective. If all documents are not provided within the eligibility period or during the open enrollment period, your dependents will not be covered this plan year. You will need to wait until the next open enrollment to add your dependent.*

In order to enroll any dependents for coverage under your district's insurance plans, you must provide documents showing that they qualify for dependent status. The following outlines who qualifies as a dependent and what documents are required:

Please present the following documents to your District Treasurer's or HR Office:

Spouse: Your legally married (including same sex) spouse, not legally separated or divorced.

Documents required:

1) Marriage certificate that has been filed with court **AND**
2) First page of your most recent Federal tax form (1040) showing that you are still married. Please black out Social Security numbers and financial information to protect your financial privacy.

Children: Your or your spouse's natural child or adopted child and/or a child for whom you are the legal Guardian. All EPC coverages terminate on the last day of the month they turn age 26.

Documents required:

1) Birth certificate naming you / your spouse as the parent OR
2) Adoption papers naming you / your spouse as adoptee parents OR
3) Appropriate court documents naming the employee/spouse as the child's legal guardian.

SPECIAL ENROLLMENT

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease). A voluntary drop of coverage is *not* a qualifying event, and neither is a change in your spouse's benefits or premiums.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you decline enrollment for yourself or for your dependents (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

WHO ARE ELIGIBLE DEPENDENTS?

Your Legally Married Spouse: This includes same-sex marriage and common law established prior to October 1991. It does not include an ex-spouse following a divorce or a former spouse from whom you are legally separated. When a divorce or legal separation is final the district **must** be notified and the ex-spouse **must** be removed as a dependent even if you are ordered by the court to provide health insurance.

Your Children: You or your spouse's natural or adopted children, as well as children under legal guardianship to age 26 (end of the birthday month the child turns 26). This includes children who are married and/or working and/or living on their own.

DEPENDENT DOCUMENTATION:

Employees must provide proof that their dependents meet eligibility before they are enrolled in the Plan. Supporting documentation is required with the **DEPENDENT ENROLLMENT AFFIDAVIT** when adding new dependents. If documentation is not received within 30 days of the enrollment date, the dependents will be removed from your coverage, and that dependent will not be able to enroll until the next open enrollment for January, 2019

Obtaining replacement marriage/birth certificate is your responsibility and takes time. Copies may be available from the United States Department of Vital Records for the state where the marriage/birth took place. The National Center for Health Statistics may provide contact information for replacing vital records: http://www.cdc.gov/nchs/w2w.htm

DEPENDENT SOCIAL SECURITY NUMBERS:

Employees must provide valid SSN for all enrolled dependents. The ACA requires that employers and plans include all dependent SSNs on mandated 1095 reporting as of January, 2016. Failure to provide accurate SSNs can result in IRS penalties for the employer and the employee.