Reset Form

Butte Schools Self-Funded Programs

Print Form

Healthy Employees Supported by Quality, Well-Managed Programs

EMPLOYEE BENEFIT PLAN APPLICATION / CHANGE FORM

SSN | First | Middle | Last | Birthdate | Gender | Marital

Addresss | City | State | Zip | Phone | Marriage Date

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. Date of marriage/partnership: ☐ Delete dependent (enter reason in box on right)

COORDINATION OF BENEFITS This applies only to full-time employees and active school board members with a spouse/RDP covered under the medical plan. Can your spouse/RDP purchase medical coverage (individual or family) through his/her employer for a payroll deduction of less than $150 per month? *Answer "No" if your spouse/RDP is self-employed or is not employed. Answer "Yes" if your spouse elects a cash-in-lieu benefit but has the option of purchasing coverage for less than $150 per month instead. Dental and vision coverages are excluded from this policy.*

◯ 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 Dogwood plan. *Although you as an employee may be enrolled in a different plan, your spouse will be enrolled in the Dogwood plan if this box is checked. Alternatively, you may check Box A, above, and comply with the provisions of that option.*

ELECTED COVERAGE

Medical | Medical: See page 3 for criteria to select Cedar-HSA Eligible | Life | If yes, complete separate enrollment form for life coverages and input optional amounts below.

Dental | 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		
							☐ Medical	☐ Dental	☐ Vision
							☐ Medical	☐ Dental	☐ Vision
							☐ Medical	☐ Dental	☐ Vision
							☐ Medical	☐ Dental	☐ Vision
							☐ Medical	☐ Dental	☐ Vision

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, Express-Scripts or BSSP any and all records of medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation or evaluation of an application or a claim.
- I authorize BSSP or its agents, designees or representative to disclose to a hospital, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of the claim.
- This authorization shall become effective immediately and 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, Express-Scripts 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.

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

Signature | Date

Information below this is line is to be completed by district HR/Payroll Staff

HIPPA/COBRA Date

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

All coverages effective

Optional EE Life | Optional SP Life

District-paid retiree medical? ☐ Yes ☐ No

Notes, Signature and Date

Reset Form | Print Form

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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 $150 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:

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 unmarried 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.

d. A child for whom the subscriber, spouse or domestic partner is a legal guardian is concerned eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

HSA Account Authorization Form
(Complete if selecting Cedar-HSA Eligible for medical plan)

Before your HSA can be opened, you must agree to the terms and conditions outlined below. If you do not agree, you will not be eligible to
contribute to the Wells Fargo HSA. By clicking "I agree" below:

1. I am indicating that I want to establish a Health Savings Account ("HSA") at Wells Fargo Bank, N.A. ("Wells Fargo"). I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I understand that I may access the agreements governing my HSA via the Wells Fargo Health Account Manager web portal online at wellsfargo/hsa or by calling 866-884-7374. I further understand that a copy of the agreements governing my HSA will be sent to me in a "welcome packet" after my HSA is opened and that I will have seven (7) business days to revoke my HSA after the welcome packet is sent.

2. I am appointing Butte Schools Self-Funded Programs as my special agent for the limited purpose of opening a Wells Fargo HSA. As my special agent, Butte Schools Self-Funded Programs has received notice from Wells Fargo on my behalf, which explains that consistent with its efforts to help the government of the United States fight the funding of terrorism and money laundering activities, Wells Fargo obtains, verifies, and records information to identify each individual who opens a Wells Fargo HSA. Pursuant to that requirement, I have provided my name, address, date of birth, social security
number, phone number, country of citizenship and residency status to Butte Schools Self-Funded Programs and authorize Butte Schools Self-Funded Programs to forward this information to Wells Fargo so that I may establish a Wells Fargo HSA.

I agree that Butte Schools Self-Funded programs will be my special agent for account opening purposes unless and until the earlier of the following three events occurs: (i) I submit written notice to Butte Schools Self-Funded Programs that I intend to terminate this appointment, and Butte Schools Self-Funded Programs has a reasonable period of time to act on such notice; (ii) I receive my HSA "welcome packet" from Wells Fargo; or (iii) I receive a notice from Wells Fargo that my application for an HSA has been declined.

3. I am authorizing Wells Fargo to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA. This may include obtaining information from a credit reporting agency.

Signature Field _____ Date _____