ENROLLMENT FORMS

- Life Insurance Dependent and Beneficiary Form
- Delta Dental
- PreferredOne Health
- HSA & Beneficiary Form
  (required if enrolling in health insurance)
- EyeMed Vision
- Accident/Wellness

All of these insurance programs are optional and you may enroll in one or none.

If you wish to participate in the dependent care flex program, please request a program guide and enrollment form.

GROUP LIFE INSURANCE - BLOOMINGTON PUBLIC SCHOOLS

Emplolyee's Last Name	First Name	Middle Initial	Employee's Job Title

Social Security Number	Date of Birth Mo. Day Year	☐ Male ☐ Single ☐ Female ☐ Married

List of Eligible Dependents (your lawful spouse, children less than 26 years of age)

Name	Birthdate	Relationship

Primary Beneficiary		Secondary Beneficiary (only applies if no primary beneficiary is listed)	
Full Name:		Full Name:	
Date of Birth:		Date of Birth:	
Relationship:		Relationship:	
Full Name:		Full Name:	
Date of Birth:		Date of Birth:	
Relationship:		Relationship:	
Full Name:		Full Name:	
Date of Birth:		Date of Birth:	
Relationship:		Relationship:	

If more than 3 primary or secondary beneficaries, please write on back side of sheet and indiciate whether primary or secondary.

In the event of death, policy pays proceeds to the primary beneficiary. If there is more than one primary beneficiary, each receives an equal share, unless you have requested otherwise, in writing. If there is no primary beneficiary, policy pays proceeds to the secondary beneficiary. If there is more than one secondary beneficiary, each receives an equal share. To receive proceeds, a beneficiary must be living on the earlier date of the following dates:

- The date life insurance provider receives proof of your death.
- The tenth day after your death.

If there is no eligible beneficiary or if you did not name one, life insurance provider pays the proceeds in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

In the event of a dependent's death, policy pays proceeds to the employee.

Signature _____ Date Signed _____

Updated 6/12/2018

DELTA DENTAL

Delta Dental of Minnesota

Eligibility Enrollment/Update Form

Client Name ISD 271 Bloomington Public Sch | Client/Subclient # 00489 -

PART A – PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):

Type of Update: ☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination ☐ Transfer

Transfer From: Client/Subclient #	Transfer To: Client/Subclient #	Change is for: ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner
-	-	

PART B – SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):

Subscriber Name (Last)		(First)	(Middle initial)	Gender
Social Security Number	Birth Date (Month-Day-Year)	Effective Date (M/D/Y)	Hire Date (M/D/Y)	
Street Address			☐ Check here if this is a new address	
City	State	Zip Code	Status* ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving	

PART C – DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):

Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (M/D/Y)	Social Security Number-requested but not required**	Status*
Spouse/ Domestic Partner					☐ Legal ☐ Surviving
Dependent Child					Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student

*see reverse side for instructions and explanation of codes
**Social security number only requested for dependents with same date of birth

PART D - SUBSCRIBER AND CLIENT SIGNATURE – Sign and date form as verification of your enrollment

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my Employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Do you or your dependents have other dental coverage? Yes No

Name of Carrier _____ Policy/Identification Number _____

Employee Signature: _____ Date: _____

Client Representative Signature _____ Date: _____

For Employer Use Only:
Qualifying Event (see next page for list of qualifying events) _____ *Date of Qualifying Event:* _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Plan Enrollment/Update Information - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/ Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse or domestic partner

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Full Time Student: An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Qualifying Events (for Employer Use Only) -

A – Adoption
B – Birth
D – Divorce/Legal Separation
E – Death
L – Loss of Coverage
M - Marriage
O – Open Enrollment
S – Dependent No Longer Eligible
T - Termination/Reduction of Work Hours
V – Employee Total Disability
X – Employee Eligible for Medicare

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

PreferredOne®
ADMINISTRATIVE SERVICES

MEMBER ENROLLMENT FORM

P.O. Box 59212
Minneapolis, MN 55459-0212
Customer Service (763) 847-4477 1-800-997-1750

Please use black or blue ink only. Do not highlight any areas on this form.

EMPLOYER TO COMPLETE

NAME OF EMPLOYER	GROUP NUMBER	CLASS	SUB-GROUP	PRODUCT

☐ New Hire
☐ Open Enrollment
☐ MN Continuation (COBRA)
(begin date): _____
☐ Early Retiree: _____
☐ Retiree

Special Enrollment Event: *(date of event)*: _____
☐ Employment Termination/Reduction in Work Hours ☐ Child Loses Dependent Status ☐ Death
☐ Employer Contributions Terminated for Non-COBRA Coverage ☐ Involuntary Loss of Other Coverage*
☐ Divorce/Legal Separation ☐ Birth ☐ Adoption/Placement for Adoption* ☐ Marriage
☐ COBRA Exhaustion ☐ Qualified Medical Child Support Order* ☐ Move outside of HMO Service Area
☐ Eligibility/Loss of Child Health Insurance Program (CHIP)/Medicaid*
☐ Loss of Minnesota Care*
☐ Other Reason: _____ *(*provide documentation)*

HOURS WORKED PER WEEK

START DATE OF FULL-TIME EMPLOYMENT _____/_____/_____ (month day year)

COVERAGE EFFECTIVE DATE _____/_____/_____ (month day year)

SIGNATURE OF EMPLOYER **X** _____

DATE SIGNED _____/_____/_____ (month day year)

EMPLOYEE TO COMPLETE

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

STREET ADDRESS / APT. NO.	CITY	STATE	ZIP CODE

EMPLOYEE'S TELEPHONE HOME ( ) BUSINESS ( )	EMAIL ADDRESS	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

PRODUCT	NETWORK

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races

HISPANIC/LATINO: ☐ Yes ☐ No

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

Do you or any family members listed below have other health coverage in addition to this plan? ☐ NO ☐ YES
If YES, name(s): ☐ Single coverage ☐ Family coverage
Name of insurance company:

Are you enrolled in Medicare Part A, B or D? ☐ NO ☐ YES
If YES *(attach a copy of Medicare card)* effective date: Part A _____ Part B _____ Part D _____

Is your spouse and/or dependent enrolled in Medicare Part A, B or D? ☐ NO ☐ YES Name: _____
If YES *(attach a copy of Medicare card)* effective date: Part A _____ Part B _____ Part D _____

Reason for Medicare Coverage: ☐ Age 65 or older ☐ Under age 65 with a disability ☐ Under age 65 with end stage renal disease

Do you or any family members included on this enrollment form have past or current medical coverage through a contract or plan through PreferredOne Community Health Plan (PCHP), PreferredOne Administrative Services (PAS), or PreferredOne Insurance Company (PIC)?
☐ NO ☐ YES If YES, please provide Employer Name (for group coverage): _____
Name(s) of all covered person(s): _____

By executing and submitting this enrollment form, you give PIC/PCHP permission to view all claims history for you and your family members as a result of such coverage except for claims history that PAS obtained acting in its capacity as a preferred provider organization (PPO).

FILL IN THE FOLLOWING INFORMATION FOR EACH ELIGIBLE DEPENDENT TO BE ENROLLED

DEPENDENT ONE

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE

RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEPENDENT TWO

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE

RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEPENDENT THREE

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE

RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

DEPENDENT FOUR

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	M.I.	☐ MALE ☐ FEMALE

RELATIONSHIP	DATE OF BIRTH *(Month/Day/Year)*	SOCIAL SECURITY NUMBER *(For Mandatory Federal/IRS Reporting[1])*

OPTIONAL *(Fill in all that apply)*
RACE/ETHNICITY: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Two or More Races
HISPANIC/LATINO: ☐ Yes ☐ No
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Hmong ☐ Cushite ☐ Vietnamese ☐ Chinese ☐ Russian ☐ Laotian ☐ Amharic ☐ Karen ☐ German ☐ Arabic ☐ Mon-Khmer Cambodian ☐ French ☐ Korean ☐ Tagalog ☐ Other: _____

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ YES ☐ NO
If NO, list dependent(s) name and address: _____
If last name is different for dependents, please explain why: _____
Are any age 26 or older dependents listed above incapacitated and incapable of self-sustaining employment because of physical disability, developmental disability, mental illness or mental health disorder and dependent on the employee for a majority of their financial support and maintenance? ☐ NO ☐ YES
If YES, list dependent(s) and date of onset of physical or mental disability and please provide supporting documentation as proof of incapacity.
_____

[1] Federal law requires that we ask for Social Security Numbers for mandatory reporting to the IRS each year. This field is requested but not required. Please note that the numbers are not used in determining eligibility for coverage.

MEMBER NAME _____ SOC. SEC. # _____

MEMBER ENROLLMENT FORM

FOR USE WITH SELF-INSURED DENTAL COVERAGE ONLY

Are any of the above listed dependent(s) age 19 or older, students? ☐ NO ☐ YES

If YES, please indicate the name, school attending and status

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

NAME _____ SCHOOL _____ ☐ Part-time ☐ Full-time

If you are declining major medical expense coverage for yourself or your dependents (including your spouse) because of other medical coverage, complete the box below.

I DECLINE COVERAGE FOR: ☐ Self ☐ Spouse ☐ Children ☐ Medical ☐ Dental

I am NOT applying for coverage because I have coverage through: ☐ Spouse's Group Plan ☐ Medicare ☐ COBRA/State Continuation ☐ MNCare ☐ Individual Policy ☐ Medical Assistance ☐ Other coverage reason: _____

Alternately, I am NOT applying for coverage because of: ☐ Cost ☐ Network ☐ Other reason: _____

I freely and voluntarily decline coverage as indicated above.

_____ _____

Date Employee Signature (If declining coverage)

NOTE: You and your dependents in the future may be eligible to enroll in this plan, provided that you apply for coverage within 31 days after other coverage ends, you lose eligibility for coverage or the employer stops contributing to your coverage. If you newly gain a spouse or eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new spouse, along with your new dependent, provided that you apply for enrollment within 31 days after marriage and a covered employee may, within 60 days, enroll their newborn dependent child acquired as a result of birth, newly adopted dependent child or dependent child newly placed with the employee for adoption.

AUTHORIZATIONS for PreferredOne Administrative Services, Inc. (PAS) and Others to Receive, Disclose and Use ("Share") Your Health Information

I, for myself, and as applicable, any minor dependents, spouse or dependents age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby authorize PAS to use and disclose my health information, including my protected health information as defined by HIPAA, claim information and explanation of benefits information ("Health Information"), to any health care provider and any subcontractor of a health care provider or of PAS that provides services for, or in connection with the medical plan option in which I am enrolling with this form; and I also authorize health care providers and the contractors and/or subcontractors of health care providers to use and disclose my health information to PAS with all such disclosures described herein between PAS, health care providers and contractors and/or subcontractors of health care providers for the purpose of managing my overall health status, my health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; and for claim processing and payment purposes. This authorization also specifically allows PAS, health care providers and contractors and/or subcontractors to share my health information about care I have received or may receive in the future.

I, for myself, and as applicable, any minor dependents, spouse or dependents age 18 or older covered by the medical plan option in which I am enrolling with this form, hereby authorize PAS, my health plan, my insurer, and my providers to share my health information specifically by and with, but not limited to, the following:

- PAS, for its plan administration, payment and/or operations
- Providers – with respect to coverage and payment; so that individually and collectively they can better manage my overall health status and my specific health conditions and diseases, through care coordination, quality improvement, and disease management functions, and/or various payment arrangements; and in their role as accountable care-type organizations or networks or under other designated financial or contractual arrangements
- Payers - Medicare, Medicaid and/or any other government health care programs, any other insurance company, health maintenance organization, payer network organization including an accountable care-type organization or network or other payer, and the contractors and subcontractors of such entities, for the payment and operations purposes of PreferredOne and each of them
- PAS's contractor and subcontractor service providers, including but not limited to PreferredOne's controlled group affiliates ("affiliates") – that assist PAS in carrying out its plan administration, payment and operations functions–including but not limited to coordinating benefits between payers, coordinating out-of-pocket payments for medical and pharmacy claims, pharmacy benefit management, disease and care management, utilization review and management, and other customer service and health claim-related activities

I understand and agree as follows:

- I will execute and submit all authorizations required by any third party (e.g., providers) for the release of my Health Information to PAS for plan administration, payment and/or operations purposes.
- My "Health Information" includes, but is not limited to, my "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and my "health records" and includes my past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes, and information derived from them. These specifically include claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment.
- I am not allowed to modify the authorizations in this enrollment form; and if I do so, the enrollment form will not be valid.

- This authorization shall remain valid as long as I am enrolled in health care coverage provided through my employer health plan and administered through PAS, unless I revoke it as described below. A copy of this authorization is as valid as the original.
- This authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with my employer health plan, PAS, its affiliates and/or any providers. This authorization and any expiration or revocation thereof does not affect or change the routine sharing of my Health Information by my employer health plan, or between PAS, its affiliates and/or any providers, that is permitted or required under HIPAA or applicable state law.
- Information released pursuant to this authorization may be re-disclosed as permitted by law, in which case I understand that it may no longer be protected under federal privacy rules. I may revoke this authorization prospectively at any time, but only by submitting a valid written revocation to my employer health plan, or PAS's Customer Service Department; and can obtain revocation information from the Customer Service Department by calling (763) 847-4477 or toll free at 1-800-997-1750. Such revocation will be effective only after PAS receives it, and it will not affect PAS's or others' actions taken prior to receipt of the revocation.

ACKNOWLEDGEMENTS

To the best of my knowledge and belief the answers to the questions and the statements made on this completed enrollment form are true and complete, and I agree that any telephone conversations required to clarify information on this completed enrollment form are part of this enrollment form.

I further understand and agree as follows:

- If this form is submitted because of a special enrollment event, then this form amends my original enrollment form and will be incorporated into and made a part of the enrollment form and Summary Plan Description.
- Payment of a claim does not prevent PAS or my employer from denying future claims or taking any lawful action it determines appropriate, including rescission of coverage and seeking repayment of claims already paid.
- If PAS or my employer approves this enrollment form, it will issue a Summary Plan Description for me and, if applicable, the dependents listed in this form.
- In the event of a conflict between this enrollment form and the Summary Plan Description, the Summary Plan Description governs and PAS or my employer will administer coverage in accordance with the Summary Plan Description.
- I am not allowed to modify the acknowledgements in this enrollment form; and if I do so, the enrollment form will not be valid. PAS or my employer reserves and has the right to, in its sole discretion, request and/or rely on other documentation, to determine if any person listed in this enrollment form satisfies the requirements of this enrollment form.
- PAS or my employer will act in reliance upon the information I have provided herein.
- **I must update and notify PAS or my employer of any change to the information that I have provided on this enrollment form that takes place between submission of the enrollment form and the effective date of coverage; and, failing to notify PAS or my employer of any change, providing false information or the omission of relevant information on this enrollment form which materially affects either the acceptance of risk or hazard assumed by PAS or my employer may result in denial of claims, rescission of coverage, or an increase in contributions, and may be considered insurance fraud.**
- **I must also notify PAS or my employer after coverage is effective of any changes to my information including my email address.**

If my employer offers coverage for domestic partners, and I elect coverage for my domestic partner, I certify that my domestic partner and I: share the same permanent residence; are jointly responsible for basic living expenses; are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely; are not related by blood closer than permitted under Minnesota marriage laws; are each mentally competent to consent to a contract; have completed or will complete a domestic partner affidavit form and have agreed or will agree to the conditions of such form.

If PAS or my employer issues coverage to me, I consent to receiving, through my secure member home page at www.preferredone.com, electronic delivery (in lieu of paper delivery) of the following information to the extent that PAS makes them available electronically: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PAS will notify by email when such information is newly available, of the document's significance, and how to access the document at www.preferredone.com. I also consent to PAS notifying me exclusively via email at the email address I provided herein, of the availability of explanations of benefits. I understand that I may request a paper copy of these documents and/or to opt out of exclusively electronic delivery by contacting PAS' Customer Service Department at 1-800-997-1750 or (763) 847-4477 or accessing www.preferredone.com.

SIGNATURE

By signing below, I certify under penalty of perjury that: (i) I have completely read and fully understand the terms and conditions of this enrollment form; (ii) all the representations in this enrollment form are made by me and are true and complete; and (iii) I agree to the statements, authorizations, acknowledgements and terms of this enrollment form. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally responsible for all claims affected by such misrepresentation. I understand that I may be subject to penalties under law if I provide false or untrue information.

Applicant signature	Date	Print full name
Spouse (if applying for coverage)	Date	Print full name
Dependent signature (age 18 and older applying for coverage)	Date	Print full name
Dependent signature (age 18 and older applying for coverage)	Date	Print full name

Office of Human Resources

Phone 952.681.6440
Fax 952.681.6449

Educational Services Center
1350 West 106th Street
Bloomington, MN 55431-4126

www.bloomington.k12.mn.us

HEALTH SAVINGS ACCOUNT (HSA) FORM

Complete the information below and return form to Human Resources, attention: Vickie Hepler, phone 952-681-6444 or e-mail vhepler@isd271.org. Please allow 10 business days for changes to be processed.

Eligibility	☐ **ELIGIBLE**: I certify that I am eligible for an HSA and the District HSA contribution (see conditions below). If this is a new HSA, my HSA will begin on the first of next month. Optionally, if I want to start or modify my employee contributions, I will complete the *Employee Payroll Contribution* section below. **CERTIFICATION OF ELIGIBILTY** *I understand that, in order for the District to contribute to a HSA on my behalf through the HSA Contribution Plan, I must meet all of the following HSA eligibility conditions:* 1. *I have single, E+1, or family high deductible health plan (HDHP) coverage under the District group health insurance program, which I understand qualifies as a HDHP under IRS Code § 223(c)(2).* 2. *I cannot be claimed as another person's tax dependent.* 3. *I have not received Medicare or TriCare benefits. I have not received VA benefits in the last three months except for a service connected disability.* 4. *I have health coverage only through the District. If I have health coverage elsewhere, that coverage is either: (a) HDHP coverage (see paragraph A on following page); or (b) permitted non-HDHP coverage (see paragraph B on following page).* 5. *I do not currently have a Medical Expense Flexible Spending Account (Medical FSA) from a previous job.* 6. *If I am married, I am not covered by my spouse's health insurance, unless it is a qualifying HDHP (see paragraph C on following page for explanation and exceptions).* 7. *If I am married, my spouse does not have a Medical FSA (see paragraph C on following page for explanation and exceptions).*
	☐ **INELIGIBLE**: I am not eligible for an HSA account.
	☐ **LOSING ELIGIBILITY**: I currently have an HSA account, but effective _____ (date), I will be no longer eligible. I realize the district contribution and my employee payroll contribution (if previously selected) will cease and I will be responsible for any fees associated with my HSA account, if any.
OPTIONAL **Employee Payroll Contribution**	☐ **EMPLOYEE CONTRIBUTION-PER PAYCHECK**: I would like to start or change my employee HSA payroll contribution. Please deduct $_____ **per paycheck**, beginning with my paycheck on _____ (date). I will allow 10 business days for processing.
	☐ **EMPLOYEE CONTRIBUTION-LUMP SUM**: I would like to make a **one-time lump sum** contribution to my HSA. Please deduct $_____ from my paycheck on _____ (date). I will allow 10 business days for processing. My current HSA payroll deduction, if any, will continue, unless I indicate otherwise.
Name or Address Change	The individual account owner must change name and address information; the District cannot make name and address changes for HSA accounts. I will log on to my Health Equity account (www.healthequity.com) and click on "profile" to change this information or call Health Equity Customer Service at 866-346-5800.

By signing this form and returning it to Human Resources, I certify that all of the statements above are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions and I agree that I will notify Human Resources immediately in writing, if I cease to be eligible. I also understand that the District will make contributions to an HSA on my behalf on the basis of my certification and that the District HSA contributions and my employee HSA contributions (if any) are subject to certain aggregate limits under federal tax law (see following page).

My Signature	Print Name	Employee #	Date

IRS REGULATIONS (Current as of January, 1, 2021)

A. HDHP coverage is health coverage that meets the following requirements:

- **Self-only (Single) Coverage**: Self-only coverage is coverage of one individual. To qualify as HDHP coverage, it must have a deductible of at least $1,400 for 2021 before any reimbursement is made for eligible medical expenses (other than preventive care). In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-pays and co-insurance, but not premiums) cannot exceed $7,000 for 2021.
- **Family (and E+1) Coverage**: Family coverage is any coverage other than self-only coverage. Family HDHP must have a deductible of at least $2,800 for 2021 before any reimbursement is made for eligible medical expenses (other than preventive care). No amounts can be paid (other than for preventive care) until the minimum required family deductible has been satisfied. In other words, there cannot be an individual deductible within the family deductible that is less than the required minimum of $2,800 for 2021. In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-payments and co-insurance, but not premiums) cannot exceed $14,000 for 2021.

B. Permitted non-HDHP insurance:

- Insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., home-owner or auto insurance), or similar liabilities as specified by the IRS;
- Insurance for a specified disease or illness (e.g., cancer insurance);
- Insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance);
- Coverage for accidents, disability, dental care, vision care, or long-term care;
- Coverage under some medical reimbursement accounts and health reimbursement arrangements (HRAs) (e.g., limited purpose medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs); or
- Coverage under some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventive medical care or treatment).

C. Special Rules for Married Individuals:

- If your spouse has family coverage under another plan (that includes you), this coverage must qualify as HDHP coverage in order for you to be eligible for HSA deposits. For example, if your spouse has family coverage (that includes you) under an HMO or a low-deductible plan, then you would be ineligible for HSA deposits.
- Similarly, if your spouse has a medical reimbursement plan (HRA, VEBA, MSRS HCSP, MSA, etc.), this disqualifies you from HSA deposits, unless your spouse's plan "excludes" you and all dependents on your HDHP –**or**– your spouse's plan has been "suspended".
- In addition, if your spouse has a medical flex spending account (medical FSA), this disqualifies you from HSA deposits, unless the balance in your spouse's account is zero at the end of your spouse's plan year or grace period (this may be earlier, if so advised by your financial advisor) –**and**– your spouse will not re-enroll in a medical FSA next year.
- In addition, the amount of your total HSA deposits may be limited per IRS regulations, if your spouse has HDHP family coverage and an HSA.

Beneficiary Designation Form

Please mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
15 W Scenic Pointe Dr, Ste 400 Draper, UT 84020

Fax: 801.727.1005

Complete this information online under "My Profile" in your member portal.

Note: If married, living in a community property state (CA, ID, LA, NV, NM, TX, WA, or WI), and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation and you must submit a physical copy of this form by mail or fax.

You have the option to list one or more persons to be the primary and contingent beneficiaries for your HSA (including your estate or a trust, as applicable). If designating multiple primary or contingent beneficiaries, indicate the percentage share each should receive, ensuring the total of each adds up to 100%.

Designations are effective upon receipt by HealthEquity and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

Account Holder Information (all fields are required)

Last Name	First Name		M.I.
E-Mail Address	Daytime Phone ( )	SSN or 6-Digit HealthEquity Account Number	

Primary Beneficiary(ies)

To ensure timely completion of your request, please complete all fields for each beneficiary you designate.

Primary Beneficiary 1 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 2 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 3 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Primary Beneficiary 4 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Contingent Beneficiary(ies)

Contingent beneficiaries receive your HSA assets in the event that all of your primary beneficiaries pass away before you.

Contingent Beneficiary 1 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Contingent Beneficiary 2 Estate/Trust ☐ Yes ☐ No

Name		SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State	ZIP
Relationship			Percent %

Total 100%

Authorization

Participant Signature	Name (please print)	Date

If you're a resident of a community or marital property state and have designated a beneficiary other than, or in addition to, your spouse, have your spouse authorize the designation by signing below.

Spousal Consent: I am the legal spouse of the HSA account holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the tax consequences of giving up my interest in this HSA, I have been advised to see a qualified tax professional. I hereby consent to the beneficiary designation(s) indicated above.

Spouse's Signature	Name (please print)	Date

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Combined Insurance Company of America
New York Residents only: Combined Life Insurance Company of New York
The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9876905	Bloomington School District 271				

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

ACCIDENT INSURANCE APPLICATION (MN)

ReliaStar Life Insurance Company, Minneapolis, MN
Administrative Office: PO Box 122, Minneapolis, MN 55440-0122

PLAN INFORMATION

Group Policyholder Name Bloomington Independent School District #271

Group Number 65768-9

ENROLLMENT TYPE

☐ Initial Enrollment ☐ Regular Enrollee[1] (New Hire) ☐ Special Enrollment

☐ Re-Enrollment ☐ Late Entrant[2] ☐ Other _____

[1]A regular enrollee is a new employee applying at the first available opportunity.
[2]A late entrant is an employee applying after the first available opportunity, with the exception of special enrollment offers.

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____

Birth Date *(Month, Day, Year)* _____ Social Security # _____ Gender: ☐ Female ☐ Male

E-mail Address _____

Residence Address _____ City _____ State _____ ZIP _____

Residence or Cell Phone (_____)_____ Work Phone (_____)_____

Proposed Effective Date of Coverage OR Date of Change *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

Hire Date *(Month, Day, Year)* _____ Job Title / Occupation _____

Employee ID # _____ Employee Class _____

Is the Employee Actively At Work? ☐ Yes ☐ No The Employee is Scheduled to Work _____ Hours Per Week

Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Department # _____ Location # _____

COVERAGE REQUESTED

☑ Employee Accident Insurance
☐ Spouse Accident Rider
☐ Children's Accident Rider

Is each person to be insured also covered under a Qualified Major Medical Plan? ☐ Yes ☐ No
(Persons who are not covered by a qualified major medical plan are not eligible for this coverage.)

SPOUSE INFORMATION *(Complete only if applying for Spouse Accident Rider.)*

Name *(First, Middle Initial, Last)* _____ Gender: ☐ Female ☐ Male

Birth Date *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

ACKNOWLEDGMENTS AND AUTHORIZATIONS

Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

It is understood and agreed that this application shall be made a part of the coverage applied for and that no insurance shall be effective until approved by the company at its home office, regardless of when the first premium is paid.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through ReliaStar Life Insurance Company. This authorization and assignment will remain in effect until revoked by me in writing to my Employer. I understand that my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am in active employment.

This application is part of the Policy and subject to the terms and conditions of the Policy. I understand that no agent, representative or employee of ReliaStar Life Insurance Company, my Employer or any other entity may change or waive the requirements of this application, or the terms of the Policy, the Certificate or any riders, except as specifically set forth in the Policy.

➡ Employee Signature _____ Date _____

Signed At *(City & State)* _____