Hanford Joint Union High School

Universal Enrollment and Change Form

Plan Enrollment – Health, Dental & Vision

Reason for Enrollment:

- ☐ New Enrollment
- ☐ Add Dependent
  - ☐ Marriage (Date of Marriage _____________)
  - ☐ Birth/Adoption (Date of Birth/Adoption___________)
  - ☐ Other (Specify_______________________________)
- ☐ Open Enrollment
- ☐ Terminate Subscriber & Dependent
- ☐ Terminate Dependent(s) Only
- ☐ Address Change
- ☐ Name Change (Former Name_________________________)

Applicant Information:

Employee Name (Last, First, Middle)			Social Security Number		Date of Birth
Address	City		State	Zip	Date of Hire
☐ Male ☐ Female	☐ Single ☐ Widowed ☐ Married ☐ Divorced	Home Phone Number	Work Phone Number		Effective Date

Enrollment Options:

All-Medical/Vision/Dental	Medical Only	Dental/Vision Only
☐	☐	☐

Family Members (please list all family members to be covered):

	Name	Relation	SSN	Sex	Birth Date	Disabled	Other Ins. Coverage
☐ Add ☐ Delete		☐ Spouse ☐ Domestic Partner		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N
☐ Add ☐ Delete		☐ Son ☐ Daughter ☐ Step Child		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N
☐ Add ☐ Delete		☐ Son ☐ Daughter ☐ Step Child		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N
☐ Add ☐ Delete		☐ Son ☐ Daughter ☐ Step Child		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N
☐ Add ☐ Delete		☐ Son ☐ Daughter ☐ Step Child		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N
☐ Add ☐ Delete		☐ Son ☐ Daughter ☐ Step Child		☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N

Authorization to Obtain or Release Medical Information:

I AUTHORIZE any physician, dentist, medical practitioner, hospital, clinic, or other medically related facility, insurance company, employer, union or group policyholder to furnish to Health Now, Delta Dental, and VSP its agents or representatives any and all records or information pertaining to eligibility, medical history, treatment, diagnosis and prognosis with respect to me, my spouse, or my children who are included under my coverage for purposes of review, investigation, or evaluation of a claim.

I AUTHORIZE Health Now, Delta Dental, and VSP, its agents or representatives to disclose any information obtained to an insurance company, reinsurance carrier, group policyholder, or other persons or organizations performing direct administrative, professional, medical or legal services in connection with my claim.

I UNDERSTAND the information obtained by use of this Authorization will be used by Health Now, Delta Dental, and VSP to determine eligibility for benefits and for the purpose of reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

I UNDERSTAND that I am entitled to a copy of this signed Authorization if I request it, and certify by signature that information contained herein is true and correct.

I approve the above authorization and make application for membership for myself and my eligible family members and authorize my employer to make the necessary deduction, if any, from my wages or salary for the contributions required of me for this coverage. I certify the information contained herein is true and correct.

Employee Signature: ____ **Date:** ___________________________

Coordination of Benefits:

☐Yes ☐No **Do you or any of your dependents have any other health, dental, and/or vision insurance in addition to this coverage?**

☐Yes ☐No **Will that coverage remain in effect after this coverage begins?**

Other Medical Coverage Information

Name of Insured:		**Social Security Number:**	
Insured's Employer:		**Name of Insurance Carrier:**	
Employer Street Address:			

City:		**State:**		**Zip:**		**Phone:**	

Other Dental Coverage Information

Name of Insured:		**Social Security Number:**	
Insured's Employer:		**Name of Insurance Carrier:**	
Employer Street Address:			

City:		**State:**		**Zip:**		**Phone:**	

Other Vision Coverage Information

Name of Insured:		**Social Security Number:**	
Insured's Employer:		**Name of Insurance Carrier:**	
Employer Street Address:			

City:		**State:**		**Zip:**		**Phone:**	

REFUSAL OF COVERAGE

Declining Coverage For:	Reason for Declining Coverage:
☐ **I decline coverage for myself, my spouse, and all dependents**	☐ **Covered by another employer's plan (e.g., through your spouse)**
☐ **I decline coverage for my:**	Carrier Name and ID Number _____
☐ **Spouse Only**	☐ **Covered by an Individual Plan**
☐ **Children Only**	Carrier Name and ID Number _____
☐ **Spouse & Children**	☐ **Medicare**
☐ **Following Dependents Only:**	☐ **Covered by TriCare or Champus**
_____	☐ **Other - e.g., any other individual or employer coverage**
_____	Explain: _____
_____	☐ **No other employer coverage**

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse and/or my dependent(s) in my employer plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer benefit plan, I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Employee Signature: _____ **Date:** _____