Location/Department

Washoe County School District
Group Benefit Programs

ENROLLMENT FORM

PLEASE PRINT OR TYPE

Last Name	First Name	MI	SSN	Hire Date	Insurance Effective Date

Address	City	State	Zip Code	Date of Birth	Phone

1. Select Health Plan:

☐ **Preferred Provider Organization (PPO)** ☐ **Qualified High Deductible Health Plan (QHDHP)**

2. Status: Certified ☐ Education Support Professional (ESP) ☐ Administrator/ProTech ☐ Confidential ☐ **Sex:** Male ☐ Female ☐ Unspecified ☐

3. Marital Status: Married ☐ Divorced ☐ Single ☐ Widowed ☐ Domestic Partner ☐

Does your spouse work for the District? Yes ☐ No ☐ If Yes is s/he covered by District medical insurance? Yes ☐ No ☐

4. Coverage: Employee ☐ Emp+ Spouse ☐ Emp+ 1 Child ☐ Emp+ 2 Children ☐ Emp+ Family ☐

5. Basic Life Insurance: ☐ **$40,000 CERTIFIED/ESP** ☐ **$50,000 CONFIDENTIAL** ☐ **$250,000 ADMIN/PROTECH/PSYCHOLOGIST**

6. Enrollee (Dependent) Information: List only the dependents you are adding to coverage. Social security number is needed for all covered dependents. You will need to submit the appropriate documentation for dependent eligibility verification that is marriage/birth certificate, domestic partnership or latest tax return.

Relationship	Last Name	First Name	MI	Birthday	M/F	*Dependent Social Security #	Elig Docs
Spouse							☐
Child							☐
Child							☐
Child							☐
Child							☐

7. Voluntary Benefits

(Must check yes or no for each benefit.)

	Yes	No	Life Insurance Amount
Additional Term Life	☐	☐	$ _____
Comprehensive Legal Plan	☐	☐	$ _____
			$ _____

8. Section 125 Plan Pre-Tax Annual Election:

(Must check yes or no)

Type: Pre-tax Eligible Premiums Yes ☐ No ☐

Employee Certification:

With my signature, I hereby declare, certify and state under penalty of perjury that the information I have provided here is true and correct, that any dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. I understand that if the information I have provided is not true and correct, my dependent benefit coverage will be terminated, and I may be subject to disciplinary action, up to and including termination.

AUTHORIZATION STATEMENTS: PLEASE READ AUTHORIZATION STATEMENTS ON REVERSE SIDE OF THIS FORM BEFORE SIGNING.

Employee Signature _____ Date Signed _____

I hereby authorize the above payroll reductions as my contribution to the District's Section 125 Plan. I understand that:

- Changes in the Section 125 Plan elections can only be made during next year's Open Enrollment unless due to and consistent with a valid status change and such other events as would permit a revocation or change of election under IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. No change may be made in the Medical Expense "reimbursement account" except for termination of employment. For special rules affecting your plan, please contact the Risk Management Office.
- I understand that if the dollars allocated to be reimbursed to me under the provisions of this plan are not used for such benefits, the balance of the unused amounts cannot be carried forward into the next plan year and will be forfeited to my employer.
- Medical expenses reimbursed under this plan are not eligible as a tax deduction on my federal tax return. Dependent Care expenses reimbursed under this plan are not eligible for the Dependent Care tax credit on my federal tax return.
- Medical expenses for reimbursement include certain expenses incurred during the plan year for the diagnosis, cure, mitigation, treatment, or prevention of disease for which there has been no other reimbursement though insurance, damages, or otherwise. Certain cosmetic surgery expenses and medical insurance premiums are not eligible for reimbursement.
- I understand that during an unpaid leave of absence, contributions to the medical expense reimbursement account must be made on an after-tax basis. When I return to work, the pre-tax contribution will resume. If I terminate employment and do not elect to continue my medical expense account payments on an after-tax basis, only expenses incurred during the period of coverage will be reimbursed. Coverage under the reimbursement account ceases when the payments cease.
- Dependent Care expenses eligible for reimbursement must be provided by third-parties meeting both applicable state law requirements and federal tax law requirements. Claims may only be made for dependent care that has already been provided. Amounts allocated to the dependent care reimbursement fund cannot exceed the lesser of the amount allowed by federal law or $5,000 for the calendar year.
- I agree to notify my the District if there is any reason to believe that any item for which reimbursement has been made is not allowable under the terms of this plan.
- I will submit expense reimbursement requests on forms provided by the District or its plan administrator.
- Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage. In most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

This authorization replaces any previous authorization I have made. I also understand my after-tax deductions will also remain in effect for the entire plan year, or until I am no longer an eligible employee or I terminate employment with the District. I authorize the District to take the appropriate after-tax payroll deductions for the benefits I elected.

I also hereby request coverage for the group health plan for which I am eligible and authorize the District to make the necessary contribution deductions, if any, required for the group health plan. I give you permission to provide Anthem, any information about me and the dependents listed necessary for determining eligibility for insurance, benefits, detecting or preventing fraud or misrepresentation, audits and for claims administrative purposes. The word "you" refers to any organization or person that has records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This includes my employer, any provider of health care, insurance companies from which I have purchased insurance and other support agencies. This information may also be given by Anthem to its legal representatives and reinsurers. I will pay any required co-payments directly to the providers of health care at time of service. I agree to be bound by all terms of the plan under which I am applying for coverage. This authorization applies for as long as I have coverage under the plan. I agree that a copy of this authorization shall be as valid as the original. I certify that, to the best of my knowledge, the information shown on this form is correct. I have read and understand the terms of this application. My signature on the front of this form is acceptance of these terms.

Washoe County School District
P.O. Box 30425, Reno, NV 89520
Email address: benefits@washoeschools.net

Washoe County School District

GROUP LIFE INSURANCE ENROLLMENT/BENEFICIARY FORM

In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and designate the following in the event of my death:

EMPLOYEE INFORMATION

Last Name: First Name: DOB: Hire Date:

Address: Sex: M ☐ F ☐ Unspecified ☐

City: State: ZIP: Social Security #:

Primary Beneficiary Designation

Last Name	First Name	Relationship	Date of Birth	Address (Street, City, State and Zip Code)	Phone #	Share %
					Total:	**100%**

Payment will be made in equal shares or all to the survivor unless otherwise indicated.

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies):

Contingent Beneficiary Designation

Last Name	First Name	Relationship	Date of Birth	Address (Street, City, State and Zip Code)	Phone #	Share %
					Total:	**100%**

Payment will be made in equal shares or all to the survivor unless otherwise indicated.

If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Life Insurance Policy.

Signature of Insured

Date

Submit Completed Form to Employer and Retain Copy for Your Records