PARIS R – II SCHOOL DISTRICT

THIS FORM NEEDS TO BE SIGNED AND RETURNED TO CENTRAL OFFICE BY MAY 9, 2016

Name _____ Date of Birth_____ SS#_____

Address_____

City, State, ZIP_____

Please Select Medical Plan ❾

$1000 PPO

$2000 HSA (non-embedded - family coverage requires family deductible to be met before coinsurance applies)

$2600 HSA (embedded - single deductible does apply which makes this plan family friendly)

Declining insurance, give reason: _____

IMPORTANT NOTICES:

- Your plan year and deductible runs from **July 1, 2016 to June 30 2017**.
- Please notify Central Office of any life changes (birth, death, marriage, divorce, job loss) so they can assist with carrier notifications.
- **Your current elections will not change unless you complete a carrier form!!** If you wish to change plans, ADD spouse or child(ren) coverage, you will need to complete an application. If you wish to DROP spouse or child(ren) coverage, you will need to complete a change form. (Please see your Bookkeeper for appropriate forms if needed.)
- FOR EMPLOYEES WHO ELECT TO COVER THEIR SPOUSE AND / OR CHILDREN on the **Non-Embedded HSA** Plan (HSA 1) : By signing below I understand that the family deductible must be met before any coinsurance applies. The individual deductible does not apply to family coverage. I understand that the family out of pocket maximum must be satisfied for all family members' eligible expenses collectively. The individual out of pocket maximum does not apply to family coverage.
- By signing below, I agree that I have received and understand the benefits material and compliance documents: (please check boxes)

  Summary of Benefits and Coverage (SBC)
  Notice of Enrollment periods
  Women's Health & Cancer rights
  Newborn Act
  Basic Life portability and conversion rights
  COBRA general notice
  Medicare/CMS Creditable Coverage Notice
  CHIP Notice
  Health Insurance Marketplace Notice

Employee Signature____

Date_____________