RIALTO UNIFIED SCHOOL DISTRICT

Risk Management / Employee Benefits

HEALTH BENEFITS ENROLLMENT – ACTIVE EMPLOYEES

Employee Number	Last Name	First Name	M.I.	Social Security Number

Street Address	City	State	Zip Code	Phone Number

Email Address	Date of Birth	☐ Male ☐ Female	☐ Classified ☐Certificated ☐Management	Hire Date / QLE Date

☐ Open Enrollment ☐ New Hire Status ☐ Qualifying Life Event	☐ Full-Time (6+ hrs.) ☐ Part-Time (4-5.75 hrs.)	PLEASE DO NOT WRITE IN THE SHADED BOXES	HIRE / QLE DATE	EFFECTIVE DATE	PROCESS DATE	COMPLETED BY (INITIALS)

HEALTH PLANS

(Please select the plans you wish to be enrolled in at the time of your retirement or separation from the District)

MEDICAL ☐ CANCEL ☐ SELECT NEW

☐ **KAISER PERMANENTE:** ☐District-Paid ☐ Prorated (part-time)

☐**UNITED HEALTHCARE:** ☐District-Paid ☐ Prorated (part-time)

☐Harmony ☐Alliance

☐ **WAIVE MEDICAL COVERAGE**

DENTAL ☐ CANCEL ☐ SELECT NEW

☐ **DELTA DENTAL PPO** ☐District-Paid ☐ Prorated (part-time)

☐ **DELTACARE® USA DHMO** ☐District-Paid ☐ Prorated (part-time)

☐ **WESTERN DENTAL HMO** ☐District-Paid ☐ Prorated (part-time)

☐ **WAIVE DENTAL COVERAGE**

VISION ☐ CANCEL ☐ SELECT NEW

☐ **EYEMED BASIC** ☐District-Paid ☐ Prorated (part-time)

☐ **EYEMED "BUY-UP"** ☐District-Paid ☐ Prorated (part-time)

☐ **WAIVE VISON COVERAGE**

LIFE INSURANCE ☐ CANCEL ☐ SELECT NEW

☐ **DISTRICT-PAID BASIC LIFE INSURANCE (w/ACCIDENTAL RIDER)**

☐ **SUPPLEMENTARY LIFE INS.** ☐ **SUPPLEMENTAL ACCIDENTAL D/D**

☐ **WAIVE BASIC LIFE COVERAGE** ☐ **WAIVE SUPPLEMENTAL COVERAGE**

DEPENDENT INFORMATION

(Social Security Number is mandatory for all dependents. Attach additional pages if necessary)

Add	Drop	Last Name	First Name	MI	Social Security Number	Relationship	Date of Birth	Gender
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State
☐	☐					☐Spouse ☐Dom. Partner ☐Child/Dependent		☐Male ☐Female ☐Decline to State

IS YOUR SPOUSE/DOMESTIC PARTNER A RIALTO USD EMPLOYEE/RETIREE? ☐ **YES** ☐ **NO** **Employee Number#**_______________________

THIS FORM WILL NOT BE PROCESSED UNLESS SIGNED AND DATED AND ALL REQUIRED DOCUMENTATION IS SUBMITTED.

I understand this election will remain in effect as long as I remain eligible, or until I make another election during an annual enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and my dependents listed above for participation in the plans elected.

I understand that I am responsible for notifying the District of any change in the eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO/PPO plan member and such HMO/PPO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

I understand and acknowledge that I must submit all the required documentation in order for my eligible dependents to be enrolled in my plan benefits.

Applicant's Signature		Date	

ENROLLMENT INSTRUCTIONS

IN ORDER TO ASSIST THE DISTRICT IN ENSURING YOUR ELIGIBLE DEPENDENTS ARE PROPLERY ENROLLED, YOU MUST SUBMIT A COPY OF ALL REQUIRED DOCUMENTS TO RISK MANAGEMENT WITHIN 30 DAYS OF ENROLLMENT ELIGIBILITY.

COMPLETE THIS FORM. PLEASE LIST ALL YOUR ELIGIBLE DEPENDENTS YOU WISH TO HAVE ADDED; IF NECESSARY, ATTACH AN ADDITIONAL SHEET OF PAPER TO THIS FORM.

You will need the following documentation for EACH eligible dependent you are enrolling:

- Social Security Number or ITIN
  - Newborns: Social Security Number must be provided within 90 days of birth.
- For Spouse or Domestic Partner: Marriage Certificate / State-Certified Certificate of Domestic Partnership
  - If your Spouse or Domestic Partner is a District Employee, please check the box on the form and provide employee number if known.
- For Eligible Dependent Children (under age 26 / non-active military)
  - Newborns: A Letter of Verification from the hospital is acceptable to enroll your child. A copy of the Birth Certificate must be provided within 90 days of birth.
  - Natural children – Certificate of Birth
  - Stepchildren – Certificate of Birth and a copy of your Certificate of Marriage to the birth parent.
  - Guardianship/Adopted Children: Copy of court documentation verifying the legal custody of the child(ren).
  - Disabled Dependent: For dependents exceeding age 26, but eligibility is due to a disability. The dependent must meet the disability standards of the benefit plan in which they are enrolled. A letter from the primary care provider (PCP) should be submitted to remain on benefit plans.

If a document is from a country outside the U.S. and is written in a foreign language, the official document must be apostilled (apostille is a method of certifying a document for use in another country) or a certified English translation should be attached.

EFFECTIVE DATES

Coverage will commence on the first day of the month following your eligibility date, provided our office has received your HEALTH BENEFITS ENROLLMENT FORM along with the required documentation within 30 days of eligibility.

PLEASE NOTE: **I***f required documentation is not received for eligible dependents within the allotted timeframe, they will not be covered under your benefits plans at the time of your enrollment. You will, however, be able to add said dependents during our annual open enrollment period*

TERMINATION DATES

Coverage will be terminated on the last day of the month in which the employee or eligible dependents became eligible.

Example 1: **Dependent** *turns age 26 on October 7, coverage terminates October 31.*

Example 2: **Employee** *separates from the District on March 20, coverage terminates March 31 (Please refer to* ***CONTINUATION OF HEALTH BENEFITS ENROLLMENT FORM*** *for continued coverage through COBRA plans)*

RIALTO UNIFIED SCHOOL DISTRICT – Risk Management & Employee Benefits

182 E Walnut Avenue, Rialto, CA 92376

Phone: (909) 820-7700 – Exts. 2110, 2112, 2113 • Fax: (909) 879-8611

Email: riskmanagementandemployeebenefits@rialtousd.org

Website: Rialto USD Risk Management / Employee Benefits