Stafford County Public Schools

EMPLOYEE *HEALTH* APPLICATION or WAIVER

Please complete in ink and return to Payroll & Benefits Office. Use an extra sheet of paper, if necessary.

SECTION 1 - EMPLOYEE INFORMATION (PLEASE PRINT)

Last name: _____ First name_____ M.I._____

Social security # _____ Date of birth (MM/DD/YYYY) _____ Sex: ❑ M ❑ F

Street address _____ Apt. # _____

City _____ State_____ Zip_____

Daytime phone (_____) _____ Evening/Cell phone (_____) _____

❑ Married
❑ Single

SECTION 2 – WAIVE COVERAGE (IF WAIVING COVERAGE PROCEED TO EMPLOYEE WAIVER FORM ON PAGE 2)

❑ **Waive Health Coverage – STOP - PROCEED TO PAGE 2 FOR EMPLOYEE WAIVER FORM**

SECTION 3 - HEALTH PLAN ENROLLMENT AND PLAN SELECTION

❑ Enroll/New ❑ Remove dependent ❑ Change coverage ❑ Add dependent

❑ Premium ❑ Core ❑ HDHP (High Deductible Health Plan w/Health Savings Account)

SECTION 4 – CATEGORY OF COVERAGE

❑ Employee only ❑ Employee / spouse ❑ Employee / one child

❑ Employee / children ❑ Employee / family ❑ Family – Both spouses employed with SCPS

SECTION 5 - FAMILY INFORMATION

(Please list ALL dependents to be covered by this plan – Do not include yourself). *For additional children, include information on separate sheet of paper and attach to application. For a newborn without a social security number, please complete this application and provide the social security number, when obtained, to the Payroll and Benefits Office. * If a dependent is disabled or handicapped before age 26, please attach physician certification.*

Name (First, M.I., Last - if different)	**Relationship** Spouse,Son, daughter, stepson, Step-daughter, etc.	**M / F**	**Social Security #** (Mandatory for Anthem enrollment and ACA reporting)	**Date of Birth** MM/DD/YYYY	**Disabled** before age 26? Y / N *

SECTION 6 – EFFECTIVE DATE AND PRE- OR POST-TAX

Effective Date of Coverage: (Mo/ Day/ Yr.) _____ Initials _____ (Required field - must be completed and initialed by applicant)

Stafford County Public schools participates in the IRS Section 125 regulation that governs Cafeteria plans. A **cafeteria plan** is a separate written **plan** maintained by an employer for employees that meets the specific requirements of and regulations of section 125 of the **Internal Revenue** Code. It provides participants an opportunity to receive certain benefits on a pretax basis.

I elect to *Pre-tax* my monthly health premium ❑

OR I elect to *Post-tax* my monthly health premium ❑

SECTION 7 - EMPLOYEE CERTIFICATION

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy. I understand that it is discovered that I provided false or misleading information to Anthem Blue Cross Blue Shield within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.

The employee and any person authorized to act on behalf of the employee, are entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature: _____ Date: _____

For Office use only:

Group Name: Stafford County Public Schools Group Number: 048144-_____ ❑ School Op ❑ Nutrition ❑ Fleet

Date of Hire _____ Entry dates - PA _____ OPP _____ Anthem _____

Revised 5/2019

Stafford County Public Schools

Waiver of Group Health Benefits and Notice of Special Enrollment Rights

Employee Name: _____SS#/Emp#_____
Please Print

For the plan year effective ___/___/___, I am waiving coverage for:

☐ Myself ☐ Spouse ☐ Eligible Dependent(s) - List Names:

_____

_____

I am ***waiving*** *coverage* due to:

☐ My preference is not to have coverage.

☐ Coverage under my spouse's/domestic partner's plan (SCPS follows Code of Virginia 20-45.3) – Name of carrier:

_____

☐ My spouse is currently or will be contracted with SCPS –

Name _____ Location _____ Full-time or Part-time
(Circle one)

☐ Other coverage -Name of carrier: _____

This coverage is ☐ Individual ☐ COBRA ☐ Medicare/Medicaid ☐ Tricare ☐ Employer Sponsored Group Plan

Special Enrollment Notice and Certification – Please review and sign below.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents. I am declining enrollment as indicated above.

I may be able to enroll myself and my eligible dependents in a plan if I lose, or my eligible dependents lose, eligibility for that coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). I must also provide required documentation to verify the change in coverage. If I do not do so within the allowed time, I will ***not*** be able to enroll until my employer's next Open Enrollment period.

In addition, I understand that if I have a newly eligible dependent (IRS Section 125 Mid-year change… marriage, birth, adoption, or placement for adoption, etc.), I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within ***30 days*** and provide necessary documentation as required.

I understand that in order to request mid-year enrollment or obtain more information, I should contact the Payroll and Benefits Office at 540-658-6000.

_____ ___/__/____
Signature Date