

SOLVAY SCHOOLS

*Solvay Union Free School District
Office Of the Board Of Education
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Notice of Health/Dental Insurance Plans

Please be advised that if you are hired as a regular employee, working at least 20 hours per week, you have the option of enrolling in the District's health and/or dental insurance plans.

You may also enroll or make changes to your insurance during our open enrollment periods:

- Health - September and March.
- Dental - December and March.

All changes must be received in Payroll **before** the first of each open enrollment month. Changes are effective on the first of each open enrollment month.

Other changes may occur during the year due to a qualifying event. Some examples of a qualifying event are: marriage, birth, death, or loss of insurance. The effective date would be the same as the qualifying event.

If you wish to enroll in the health and/or dental insurance plans, please complete the attached forms.

Questions about either the health and/or dental plans, should be emailed to Vicki Hayduke at vhayduke@solvayschools.org or phone at 468-4942, ext. 313.

**Solvay Union Free School District
103 Third Street
Solvay, NY 13209**

FLEX Option Enrollment Form

Insurance Premiums for New Participants

As a new enrollee of the insurance plan at Solvay Union Free School District, you have the option of having your health and/or dental insurance premiums paid through the Excellus Flexible Spending Program. This results in paying your premiums on a pre-tax basis saving you valuable tax dollars. This happens through payroll and is a valuable part of your employee benefit package. There is no cost to the employee for this. If you wish to participate in this portion of the Flexible Spending Program, please check Option 1 below and sign the form in the designated area. If you choose not to participate, please check Option 2 and sign.

- Option 1: I wish to have my health and dental insurance premiums qualify as a flexible spending benefit.
- Option 2: I do not wish to have my health and dental insurance premiums qualify as a flexible spending benefit.

Signature

Date



GROUP ENROLLMENT FORM

DO NOT USE - FOR INTERNAL USE ONLY

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 - Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name, Subscriber's First Name, Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number*, Is your over-age dependent handicapped or disabled?, Yes, Female, (See last page for additional information), No, Is Dependent a full time student?, No, Yes, If yes, please indicate college/university name: College/University Name, Expected Graduation Date, Credit hours

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number*, Is your over-age dependent handicapped or disabled?, Yes, Female, (See last page for additional information), No, Is Dependent a full time student?, No, Yes, If yes, please indicate college/university name: College/University Name, Expected Graduation Date, Credit hours

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number*, Is your over-age dependent handicapped or disabled?, Yes, Female, (See last page for additional information), No, Is Dependent a full time student?, No, Yes, If yes, please indicate college/university name: College/University Name, Expected Graduation Date, Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than four dependents please use an additional form.

*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group:
 - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit:

www.excellusbcbs.com/cnycoop