North Coast Schools' Medical Insurance Group

GROUP MEMBERSHIP ENROLLMENT / CHANGE FORM

DISTRICT NAME

JPA date stamp here

Active	☐	No additions or changes will be made unless a complete application and supporting materials are attached.
COBRA	☐	If enrolling in COBRA, a completed COBRA Continuation Election Form must be attached.
Retiree	☐	If choosing to continue coverage as a Retiree, a completed Continuation of Benefits - Retirees form must be submitted.

ADD

EMPLOYEE	☐ New Hire	☐ Rehire	☐ LOA Return	☐ Increased Hours	☐ Open Enrollment	☐ Other:
DEPENDENT	☐ Newborn	☐ Child	☐ Spouse	☐ Domestic Partner	☐ Legal Guardianship	

TERMINATE

EMPLOYEE	☐ Discharged	☐ Resigned	☐ Laid Off	☐ Retired	☐ Reduction of Hours	☐ LOA	Effective Date
DEPENDENT	☐ Child	☐ Spouse or Domestic Partner					Effective Date
REASON	☐ Request	☐ Death	☐ End of Domestic Partnership	☐ Divorce	☐ Maximum Age of 26		

CHANGE

INFORMATION	☐ Address	☐ Name	☐ Benefit Group	☐ Medical Plan	Effective Date
	☐ Other (Describe):				

EMPLOYEE INFORMATION

SS#	– –
FIRST NAME	
MIDDLE INITIAL	
LAST NAME	
GENDER	☐ Male ☐ Female
DATE OF BIRTH	– –
MARITAL STATUS	☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Partnership
MAILING ADDRESS	
CITY	
STATE	ZIP
PHONE	E-MAIL

DATE OF HIRE ______ FTE ______ FT (FTE 1.0) ☐ PT (FTE <1.0) ☐ HOURS PER WEEK ______

NOTE: ALL 1.0 FTE EMPLOYEES MUST ENROLL IN ALL HEALTH BENEFITS OFFERED BY THE DISTRICT, PER NCSMIG BYLAWS

BENEFIT GROUP ☐ Classified ☐ Certificated ☐ Confidential ☐ Class Mgmt ☐ Cert Mgmt ☐ Board ☐ Superintendent

BENEFIT ELECTIONS

MEDICAL	☐ Redwood	☐ Oak	☐ Spruce	☐ Pine	☐ Maple		Effective Date
DENTAL Per Benefit Group	☐ 1	☐ 3	☐ 5	☐ 7	☐ 9	☐ 11	Effective Date
	☐ 2	☐ 4	☐ 6	☐ 8	☐ 10	☐ 12	
VISION Per Benefit Group	☐ A1	☐ A4	☐ B2	☐ B3	☐ C5	☐ C7	Effective Date
	☐ A8		☐ B6	☐ B10	☐ C9	☐ C11	

DEPENDENT INFORMATION

DEP CODES: SPS=Spouse DP=Domestic Partner M=Medical D=Dental V=Vision

SS#	First Name	MI	Last Name	Dep Code	Date of Birth	Sex	M	D	V
– –									

Date of Marriage or Domestic Partnership (Date of notarization is used for Domestic Partnerships):

DEP CODES: C=Child ST=Stepchild PC=Partner's child HC=Handicapped/Disabled child AD=Adopted child LG=Legal Guardianship

SS#	First Name	MI	Last Name	Dep Code	Date of Birth	Sex	M	D	V
– –									
– –									
– –									
– –									
– –									

ARE YOU COVERED UNDER ANOTHER NCSMIG PLAN?

SELF	☐ YES	☐ NO	DISTRICT	
SPOUSE/PARTNER	☐ YES	☐ NO	DISTRICT	
CHILD(REN)	☐ YES	☐ NO	DISTRICT	

ADDITIONAL FORMS AND/OR INFORMATION REQUIRED TO ADD/TERMINATE DEPENDENTS

☐	**MARRIAGE CERTIFICATE**	(Court clerk signed and recorded copy; keepsake copy not accepted)
☐	**DECLARATION OF DOMESTIC PARTNERSHIP**	(Notarized JPA form or official copy of Secretary of State Declaration of Domestic Partnership form)
☐	**BIRTH CERTIFICATES**	(Official County recorded copy; hospital copies not accepted)
☐	**TERMINATION OF DOMESTIC PARTNERSHIP**	(Notarized JPA Termination of Domestic Partnership form or certified copy of Secretary of State Revocation of Domestic Partnership form)
☐	**DIVORCE DECREE**	(Copy of court-issued Dissolution of Marriage form)
☐	**GUARDIANSHIP OR ADOPTION**	(Copy of court-issued paperwork awarding custody or adoption)
☐	**HANDICAPPED/DISABLED DEPENDENT CHILD 26 YEARS OR OLDER**	(Proof of prior coverage from your previous plan or employer and Declaration of Disabled child form from NCSMIG)

AUTHORIZATION - PLEASE READ CAREFULLY

I hereby authorize my physician, health care practitioner, hospital, clinic, or other professional to furnish an agent, or designee or representative of the North Coast Schools' Medical Insurance Group, NCSMIG, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for the purpose of review, investigation, or evaluation of any application or claim.

I also authorize NCSMIG or it's agents, designees, or representatives to disclose to a hospital, health care service plan, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

This authorization shall become effective immediately and shall remain in effect as is necessary to enable NCSMIG to assist in the processing of claims.

Privacy Disclosure Statement: The North Coast Schools' Medical Insurance Group, NCSMIG, understands the importance of keeping your personal and health information private. NCSMIG protects this information in electronic, written, and oral forms when used throughout our group. NCSMIG will not disclose this information without your authorization except as permitted by law. For the purpose of administering your NCSMIG coverage, NCSMIG is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, NCSMIG is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. A complete explanation of "NCSMIG Privacy Notice" for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling NCSMIG.

I understand that it is my responsibility to provide my district with any information pertaining to changes in my status, such as, but not limited to: address changes, terminations of coverage, addition or termination of dependents, Medicare eligibility for myself or my dependents due to either AGE or DISABILITY. Notice of changes must be submitted directly to my district prior to the change effective date. Addition of eligible dependents must be completed in the timeframe outlined in the Blue Shield Summary Plan Description Book. I understand that I have a Preferred Provider Plan (PPO) and may be responsible for a greater portion of my medical costs when I use a non-contracted provider. Provider status may be obtained by calling Blue Shield or the provider, as well as online under my account at www.blueshieldca.com.The North Coast Schools' Medical Insurance Group, NCSMIG, is not responsible for your failure to properly and timely notify your district of changes to your plan or for your failure to review your plan documents prior to accruing expenses.

By signing below, I understand and agree to the terms and conditions as stated in my Summary Plan Description Book and this enrollment/change form. I acknowledge that I can receive a copy of this form or the Summary Plan Description Book for any and all enrolled plans if requested by me from my employer, that all information on this form is correct and true to the best of my knowledge and belief, that this information is the basis on which coverage may be issued under these plans, and that if I have committed fraud or made an intentional misrepresentation of any material fact that my coverage may be terminated or I could be responsible for additional out-of-pocket expenses caused by such fraud or intentional misrepresentation. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Print Name	**Signature**	**Date**
District Representative Name	**Signature**	**Date**

MISCELLANEOUS