BENEFITS ENROLLMENT-TERMINATION-CHANGE FORM

North Coast Schools
Medical Insurance Group

JPA use only

DISTRICT NAME	
Active ☐	Enrollment can be delayed/denied if form is not complete or is missing required documents. Attach Guardian Life Beneficiary Designation to this form.
Retiree ☐	If choosing to continue coverage as a retiree, please use the Retiree Continuation of Benefits form (JPA-M5)

ADD — Reason to enroll

☐ Employee	☐ New hire	☐ Annual Open Enrollment	☐ Loss of Other Coverage (Provide proof of prior coverage)
	☐ Rehire	☐ Return from Leave of Absence	☐ Increased Hrs, date of increase ______
			☐ ACA look back, date determined ______
☐ Spouse / Partner	☐ Marriage/Partnership		
☐ Child / Newborn	☐ Birth ☐ Guardianship	☐ Court Order (child(ren) only)	☐ Other ______

TERMINATION — Reason for termination

☐ Employee	☐ Discharged	☐ Laid Off	☐ Leave of Absence	☐ By request
☐ Spouse/Partner	☐ Resigned	☐ Non Payment	☐ Reduction of hours	☐ Max Age 26
☐ Child	☐ Retired	☐ Death	☐ Divorce/End Partnership	☐ Other ______

CHANGE OF INFORMATION

☐ Address ☐ Phone# ☐ Name ☐ Benefit Group ☐ Open Enrollment ☐ Close of Bargaining

☐ Other(Describe) ______ Effective Date ______

EMPLOYEE INFORMATION

SS#					
FIRST NAME					
MIDDLE INITIAL					
LAST NAME					
DATE OF BIRTH		☐ MALE	☐ FEMALE	☐ UNKNOWN	
MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ DIVORCED	☐ WIDOWED	☐ PARTNERSHIP
MAILING ADDRESS					
CITY		STATE		ZIP CODE	
PHONE					
E-MAIL ADDRESS					

FOR DISTRICT USE ONLY

Date of Hire: ______

☐ Full Time
☐ Part Time
☐ Certificated ☐ Cert Mgt
☐ Classified ☐ Class Mgt
☐ Confidential ☐ Board Mbr
☐ Superintendent

NOTE: ALL 1.0 FTE EMPLOYEES MUST ENROLL IN ALL BENEFIT PROGRAMS OFFERED BY THE DISTRICT.

BENEFIT ELECTIONS

FOR DISTRICT USE ONLY/SET BY BARGAINING UNITS.

MEDICAL				DENTAL			VISION		
☐ ADD	☐ REMOVE	☐ CHANGE	Effective Date			Effective Date			Effective Date
☐ OAK	☐ SPRUCE	☐ PINE	☐ MAPLE	☐ ADD	☐ REMOVE		☐ ADD	☐ REMOVE	
☐ Oak Plus+	☐ Spruce Plus+	☐ Pine Plus+	☐ Maple Plus+	☐ D-15	☐ D-20	☐ D-30	☐ A	☐ B	☐ C

DEPENDENT INFORMATION

Spouse / Partner FIRST MI LAST	Date of Birth	Relationship	Gender	Medical	Dental	Vision
☐ ADD		☐ Spouse	☐ M	☐ Yes	☐ Yes	☐ Yes
☐ REMOVE SS# ___ ___ ___ ___ ___ ___ ___ ___ ___		☐ Partner	☐ F	☐ No	☐ No	☐ No
Date of Marriage or Domestic Partnership Notarization:			☐ Unk			

Child(ren) FIRST MI LAST	Date of Birth	C=Child ST=Step PC=Partner's Child G=Guardianship		Medical	Dental	Vision
☐ ADD		☐ C ☐ ST	☐ M ☐ F	☐ Yes	☐ Yes	☐ Yes
☐ REMOVE SS# ___ ___ ___ ___ ___ ___ ___ ___ ___		☐ G ☐ PC	☐ Unk	☐ No	☐ No	☐ No
☐ ADD		☐ C ☐ ST	☐ M ☐ F	☐ Yes	☐ Yes	☐ Yes
☐ REMOVE SS# ___ ___ ___ ___ ___ ___ ___ ___ ___		☐ G ☐ PC	☐ Unk	☐ No	☐ No	☐ No
☐ ADD		☐ C ☐ ST	☐ M ☐ F	☐ Yes	☐ Yes	☐ Yes
☐ REMOVE SS# ___ ___ ___ ___ ___ ___ ___ ___ ___		☐ G ☐ PC	☐ Unk	☐ No	☐ No	☐ No
☐ ADD		☐ C ☐ ST	☐ M ☐ F	☐ Yes	☐ Yes	☐ Yes
☐ REMOVE SS# ___ ___ ___ ___ ___ ___ ___ ___ ___		☐ G ☐ PC	☐ Unk	☐ No	☐ No	☐ No

REQUIRED DOCUMENTS TO ADD / REMOVE DEPENDENTS

Documents must be received within 30 days of eligibility date, unless adding a newborn, which is 60 days from the date of birth

Marriage Certificate	*(certified copy from County Recorder, keepsake copy not accepted)*
Declaration of Domestic Partnership	*(a notarized JPA-M20 form found online at ncsmig.org or certified copy Secretary of State declaration form)*
Birth Certificate	*(certified copy from County Recorder, hospital keepsake copy not accepted)*
Termination of Domestic Partnership	*(a notarized JPA-M21 form found online at ncsmig.org or certified copy Secretary of State revocation form)*
Divorce Decree	*(Notice of Entry of Judgment or Judgment stamped and filed by the Court Clerk)*
Disabled Dependent Child 26 yrs or older	*(proof of prior coverage from your previous employer plan and a completed Blue Shield Declaration of Disability for Over Age Dependent child form available online at ncsmig.org*

ARE YOU COVERED UNDER ANOTHER NCSMIG PLAN?

SELF	SPOUSE/PARTNER	CHILD(REN)	DISTRICT
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	

AUTHORIZATION - PLEASE READ CAREFULLY

I hereby authorize my physician, health care practitioner, hospital, clinic, or other professional to furnish an agent, 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 dependent's 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/employer with any information pertaining to changes in my status, such as, but not limited to: address, termination of coverage, addition or termination of dependents, Medicare eligibility for myself or my dependents due to AGE or DISABILITY. Notice of changes must be submitted directly to my district/employer on a JPA-M1 form prior to the change effective date, failure to do so could cause additional out of pocket expenses, termination of coverage, delay/denial of enrollment and/or additional premium responsibility. Addition of eligible dependents must be completed in the time frame as outlined in the Blue Shield Summary Plan Description Book.

North Coast Schools Medical Insurance Group (NCSMIG), is not responsible for your failure to properly and timely notify your district/employer of changes to your plan or for your failure to review your plan documents prior to accruing expenses. All voluntary terminations must be submitted on a JPA-M1 form. Form must be received prior to effective date requested. Termination effective date will be the last day of the month in which the request was received. No retroactive requests will be considered.

I understand that I have a Preferred Providers Organization Plan (PPO) and may be responsible for a greater portion of my medical costs when I use a noncontracted provider. Provider status may be obtained by calling Blue Shield or the provider, as well as online under my account at www.blueshieldca.com.

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 free of charge, 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.

I understand that this form specifies that failure to elect coverage for my eligible dependents during the initial enrollment period permits NCSMIG to impose an exclusion of coverage until the next Open Enrollment period as these dependents will be considered 'late enrollees'. By signing this form I acknowledge a refusal of coverage for those dependents.

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

MISCELLANEOUS