RETIREE CONTINUATION OF BENEFITS

COMPLETED FORM MUST BE RECEIVED WITHIN 30 DAYS OF RETIREMENT

North Coast Schools
Medical Insurance Group

JPA Use Only

DISTRICT NAME	

RETIREE INFORMATION

RETIREMENT DATE OF EMPLOYEE	
RETIREE FIRST NAME	
LAST NAME	
LAST FOUR DIGITS OF RETIREE'S SSN	
BENEFIT GROUP	☐ Cert ☐ Class ☐ Confid ☐ Cert Mgmt ☐ Class Mgmt ☐ Brd Mbr ☐ Supt

COMPLETE ONLY IF YOU ARE A SPOUSE OR PARTNER THAT IS CONTINUING BENEFITS WITHOUT THE RETIREE

☐ Spouse/partner of retiree ☐ Surviving spouse/partner retiree ☐ Not Applicable

SSN						
FIRST NAME						
MIDDLE INITIAL						
LAST NAME						
DATE OF BIRTH						☐ FEMALE
MAILING ADDRESS						☐ MALE
CITY		STATE		ZIP		☐ UNKNOWN
PHONE #		EMAIL				

SELECT COVERAGE TO BE CONTINUED

As a retiree I want to continue the following coverages *(Please check the appropriate box)*

MEDICAL	YES	NO
self	☐	☐
spouse	☐	☐
child(ren)	☐	☐

Choose Medical plan to continue as a retiree

☐ CONTINUE WITH MY CURRENT PLAN

☐ OAK ☐ SPRUCE ☐ MAPLE ☐ PINE

☐ Oak Plus+ ☐ Spruce Plus+ ☐ Maple Plus+ ☐ Pine Plus+

EFFECTIVE DATE

DENTAL	YES	NO
self	☐	☐
spouse	☐	☐
child(ren)	☐	☐

(may only continue current plan)

Current Dental Plan

EFFECTIVE DATE

VISION	YES	NO
self	☐	☐
spouse	☐	☐
child(ren)	☐	☐

(may only continue current plan)

Current Vision Plan

EFFECTIVE DATE

List Child(ren) by name

(1)	(3)
(2)	(4)

RETIREE STATUS

RETIRED EMPLOYEE

☐ Early retiree under 65 (No Medicare)		MEDICARE EFFECTIVE DATE
☐ Early Retiree under 65 (With Medicare due to disability)		Month Day Year
☐ Retiree over 65 with Medicare	Part A date effective	
☐ Retiree over 65 no Medicare	Part B date effective	

SPOUSE/PARTNER OF RETIRED EMPLOYEE

☐ Early retiree under 65 (No Medicare)		MEDICARE EFFECTIVE DATE
☐ Early Retiree under 65 (With Medicare due to disability)		Month Day Year
☐ Retiree over 65 with Medicare	Part A date effective	
☐ Retiree over 65 no Medicare	Part B date effective	

RETIREE INFORMATION - PLEASE READ CAREFULLY

As a retiree it is your responsibility to provide your district with any information pertaining to changes in your retirement status such as, but not limited to: **divorce, address, termination of coverage, termination of dependents, MEDICARE eligibility for self or dependents due to AGE or DISABILITY.** Notice of changes must be submitted directly to your School District and must be received by your School District PRIOR to the change effective date. Retroactive requests will not be considered.

Termination of coverage effective date will be the last day of the month the changes are received. **Failure to notify your district of changes to your retirement status could result in delay/denial of claim payments, termination of coverage, increased member contributions and/or out of pocket expenses.**

Once you retire and are enrolled in Medicare due to age or disability, Medicare becomes the primary payor. NCSMIG plans will be secondary (unless entitled to Medicare solely due to end-stage renal disease).

Questions regarding premium payments, cost of coverage, due dates, etc. should be directed to your School District.

AUTHORIZATIONS

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: 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 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.

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 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 district, 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.

Member's Name Printed	Signature	Date
District Representative Name Printed	Signature	Date

NOTES