LifeMap Assurance Company™
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Group Dental and/or Vision Insurance Retiree Enrollment and Change Form

For residents of Washington, the definition of a Spouse includes your legal husband or wife or your State Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

For residents of Idaho, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Please complete all information on this page and on page 2.

TO BE COMPLETED BY SCHOOL DISTRICT Please check one: PERSI Billed ☐ Direct Bill (Retro) ☐

Date of Retirement _____

Signature of School District Admin _____ Date _____

I am enrolling for: ☐ **Dental** ☐ **Vision**

Employer Name	**Group Number**
Shoshone School District #312	**ID03909I**

☐ New Group ☐ Open Enrollment ☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____

☐ Change of Existing Enrollment ☐ COBRA ☐ Non-COBRA Continuation of Coverage ☐ Cancelation

For any change to existing enrollment, cancelation, or continuation of coverage, please indicate reason below.

Retiree's Name (Last, First, MI)	☐ M ☐ F	Date of Birth
Social Security Number	☐ Married ☐ Divorced ☐ Single	Telephone Number ( )
Home Address & Apt. No./Mailing Address	City	State Zip

Dependents to be enrolled: Dependent children must be under 26 years of age.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship (Spouse, Child)	Enroll for coverage
			☐ M ☐ F		☐ Dental ☐ Vision
			☐ M ☐ F		☐ Dental ☐ Vision
			☐ M ☐ F		☐ Dental ☐ Vision
			☐ M ☐ F		☐ Dental ☐ Vision

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If changing existing enrollment, indicate reason below:

☐ **Name Change** – Former name _____ ☐ Address Change

Add Dependent(s)

Add Dependent(s) due to ☐ Open Enrollment ☐ Marriage / Domestic Partnership – Date _____

☐ Newborn - Date of Birth _____ ☐ Adoption - Date of Placement in Home _____

☐ Loss of Coverage - Date _____ Reason _____

Name of Prior Carrier _____ Telephone Number _____

Prior Policy Number _____ Identification Number _____

Coverage was ☐ Group ☐ Individual ☐ Medical ☐ Dental ☐ Vision

Coverage was for ☐ Self ☐ Spouse ☐ Child(ren) ☐ Family as listed above (check all that apply)

Please complete page 2 before signing and submitting your Enrollment or Change Form

Cancelation of Coverage

Delete Dependent(s) due to: ☐ Dependent no longer eligible – Date dependent was no longer eligible _____

☐ Death - Date _____ ☐ Divorce/Term. of Dom. Part. - Date _____

Delete ☐ All Dependents ☐ Dependent(s) Name(s) _____

Continuation of Coverage

Termination of Coverage was due to: ☐ Termination of Employment ☐ Reduction in hours ☐ Military Leave

☐ Employee's Death ☐ Other _____ Date of Qualifying Event _____

Other Coverage Information This is not a waiver of coverage. This information is required for payment of claims.

Do you or any family members enrolling have other dental coverage? ☐ Yes ☐ No **Vision coverage?** ☐ Yes ☐ No

If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage		Relationship
Name of Insurance Carrier		Carrier Phone Number ( )
Address of Other Carrier City State Zip		Effective Date of Coverage
Policy Number _____	ID Number _____	Termination Date (if applicable)
This plan covers (check all that apply) ☐ Self ☐ Spouse ☐ Child(ren)		☐ Family as listed above
Is the coverage of any dependent affected by a divorce decree/court order? ☐ Yes ☐ No If yes, please include portion of decree that shows responsibility for health expenses.		

I hereby apply for enrollment with LifeMap Assurance Company under the Group Dental and/or Vision Insurance Policy of the Employer named on Page 1. I hereby authorize PERSI pay the insurance premium until my sick leave entitlement is exhausted. If I have no sick leave entitlement or if my sick leave entitlement has been exhausted, I request PERSI continue my coverage by withholding the required premium from my requirement allowance, until otherwise notified in writing. I understand the rates and benefits are all subject to the master contract maintained by Shoshone School District #312 and LifeMap Assurance Company. I understand that my coverage may be terminated if: (a) my School District ceases to insure active employees under a group life insurance policy issued by LifeMap Assurance Company; (b) I cease to be eligible for PERSI benefits or no PERSI benefits are payable to me; or (c) I fail to pay my direct bill premium or (d) as provided under the group insurance policy coverage issued by LifeMap Assurance Company to Shoshone School District #312. If my coverage under the group policy terminates for any reason, I understand that I not be insured again under the group policy.

I acknowledge and understand LifeMap Assurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, ophthalmologist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

Insurance Fraud Warning:

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Note: The Group Vision Care Insurance Policy provides vision benefits only. Review your policy carefully.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date.

▶ _____
Employee's Full Name (please print clearly)

▶ _____
Employee's Signature

▶ _____
Date Signed