ESSDACK Health Insurance Group
BENEFIT ELECTION/CHANGE FORM - PLAN YEAR 10/01/17 – 09/30/18
USD 410 Durham – Hillsboro – Lehigh Health Insurance Group #9616109

SECTION A.

I wish to enroll in the following option effective 10/01/17: **NOTE: You can move one deductible level up (lower deductible) but one or two deductible levels down (higher deductible) during open enrollment.**

		SINGLE	FAMILY
$650 deductible:	$650/$1300 deductible, $1300/$2600 coinsurance	☐	☐
$1300 deductible:	$1300/$2600 deductible, $2600/$5200 coinsurance	☐	☐
$2000 deductible:	$2000/$4000 deductible, $3300/$6600 coinsurance	☐	☐

Please check the appropriate box (check all that apply):

☐ I am **not** making any change in my health insurance enrollment status or benefit option.

☐ I am making a change in my deductible option for the 10/01/17 – 09/30/18 plan year.

☐ This is a new enrollment or a change in my enrollment status. (A BC/BS application form or change form must be completed and attached.)

SECTION B.

If you are NOT enrolling in the ESSDACK Health Insurance Plan, please complete the following Information: **(This information is required from all employees in order to verify that your district can qualify/meet the insurance quota and for government reporting purposes. Information is kept confidential.)**

___ I am covered by my spouses or parent's insurance program.
Spouse's or Parent's Name___________________________
Place of Employment_______________________________
Name of Insurance Company_________________________

___ I am covered by an Affordable Care Act Marketplace Exchange Policy.

___ I am covered by (circle one) Medicaid, Medicare, Military, Other (list) ___________________.

___ I do not desire to enroll in Blue Cross and Blue Shield of Kansas coverage at this time and have no other insurance.

NOTICE OF ENROLLMENT RIGHTS: If you are declining enrollment for yourself or your dependents (including your spouse) because of another employer group health plan, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within a specified timeframe after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents within a specified timeframe. Check with your group administrator for details.

Employee Signature ___________________________________

Print Name ____ Date ____________________________