JEFFERSON SCHOOL DISTRICT
EMPLOYEE HEALTH PLAN

DECLINATION OF COVERAGE FORM

COMPLETE ONLY IF YOU ARE **DECLINING THE MEDICAL COVERAGE** OFFERED BY JEFFERSON SCHOOL DISTRICT

EMPLOYEE NAME (PRINT): (FIRST) (INITIAL) (LAST)	EMPLOYEE ID NUMBER OR LAST 4 DIGITS OF SSN:

I DECLINE TO ENROLL IN THE MEDICAL COVERAGE OFFERED FOR MYSELF AND MY ELIGIBLE DEPENDENTS. IN DECLINING SUCH COVERAGE, I UNDERSTAND THAT:

Initial
_____ I am declining coverage for myself and my eligible dependents.

Initial
_____ By declining coverage, I understand that I/we will not be eligible to enroll for such coverage under the plan(s) until the next open enrollment period, unless I meet the criteria stated below for a Special Enrollment exception.

Initial
_____ If one of the Special Enrollment exceptions below applies, I understand that my eligible dependents and/or I will be considered eligible to enroll during the plan year, subject to the timelines stated in the exceptions and I will not have to wait for the next open enrollment period to obtain coverage under the plan(s).

SIGNATURE: _____ DATE SIGNED: _____

SPECIAL ENROLLMENT Special Enrollment is a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage as a result of certain events that create special enrollment rights. Special enrollment events include loss of other group health plan coverage. Also, in the event of marriage, birth, adoption or placement for adoption, you may enroll yourself and your newly acquired SPOUSE* and children for coverage. Coverage will become effective on the date of the event if an application for such coverage is received by the district office within thirty-one (31) days of the event.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of the loss of eligibility for coverage or becoming eligible for a premium subsidy under Medicaid or a state sponsored Children's Health Insurance Program (CHIP). A request for enrollment must be submitted to the district office within sixty (60) days of loss of such coverage or the date of the Determination Letter advising of the eligibility for premium subsidy issued by either Medicaid or CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

HIPAA PRIVACY Escalon Unified School District is fully compliant with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

*** For employees only eligible to enroll in the SISC Bronze plan, NO SPOUSE COVERAGE IS AVAILABLE.**

Health Insurance Consortium *of San Joaquin*

JEFFERSON ELEMENTARY SCHOOL DISTRICT- CERTIFICATED

CVT BRONZE PLAN SELECTION FORM - "NON-CAP" EMPLOYEES

Date of Enrollment/Change: _____	**New Enrollment:** ❑
Date of Hire: _____	**Open Enrollment:** ❑

Last Name:	First:	M:	❑ Single ❑ Married ❑ Divorced ❑ Widowed
Street Address:	City:	State:	Zip:
Employee ID #:	Social Security Number:		Date of Birth:

2019-20 PLAN YEAR - **CERTIFICATED "NON-CAP" EMPLOYEE ONLY**

CVT ANTHEM BLUE CROSS MEDICAL PPO BRONZE PLAN	GROUP NUMBER	MONTHLY EMPLOYEE COST
70% PLAN - DEDUCTIBLE: $5,000 INDIVIDUAL / $10,000 FAMILY	1853YA	☐ $883.00 EMPLOYEE & FAMILY COVERAGE

_____ Initial — I understand that I am solely responsible for the full premium cost of the medical plan selected above, as demonstrated by checking the box under Monthly Employee Cost.

_____ Initial — I understand and agree that I must pay the full 1st month premium by check/money order by the 15th of the month prior to the start of coverage. For new hire employees, with an employment start date after the 15th of the month, the full 1st month premium is due on the on the 1st day of employment.

_____ Initial — After payment of the 1st month premium, I agree to have the monthly premium for the coverage selected above deducted from my payroll earnings prior to any elective deductions, including direct deposit elections.

_____ Initial — I further agree and understand that any payroll earnings will be available for the deduction of premium coverage selected above.

_____ Initial — I understand enrolling in this medical plan means that I cannot be enrolled in a dental or vision plan.

_____ Initial — I understand and agree that if I do not have sufficient earnings to cover the monthly premium amount due, I must pay the balance of premium due by no later than the 15th of the month of coverage

_____ Initial — I understand that it is solely my responsibility to determine the premium balance due by the 15th of the month. Although, Jefferson may provide an invoice for the balance due, lack of receipt of such an invoice does not relieve my obligation to pay the full premium balance by the 15th of the month of coverage.

_____ Initial — I agree and understand that if at any time, my checks provided for payment of any portion of medical premium are returned as unpaid from my bank for any reason (insufficient funds, closed account), this will be deemed as not having met the requirement to pay the full premium by the 15th of the month of coverage.

_____ Initial — I understand and agree that failure to pay the full premium balance due by the 15th of the month of coverage will result in immediate termination of coverage for that coverage month and for the remainder of the plan year. If my coverage is terminated for lack of payment of the full premium, I understand that such termination of coverage is retroactive to the 1st day of the coverage month and that I will be solely responsible for any and all claim costs incurred.

Employee Understanding

I understand that my signature on this CVT Bronze Plan selection form for "Non-CAP" employees means that I have read and understand all of the contents of this form.

_____ Employee Signature _____ Date

_____ Employer Signature _____ Date

White - Jefferson Canary - Employee