valueHealth
Benefit Administrators

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Group No.: BMI179-Barton Community College Level I Employee Health Care Plan **Enrollment Form**

Please note that all Demographic Information is required *

Employee Name: _____
Social Security #: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Marital Status: _____ Gender: M ☐ F ☐
Date of Birth: _____
Email Address: _____
Occupation: _____

This section to be completed by employer

Date of Hire:

Ins. Effective Date:

Division:

☐ GB/Fort Riley
☐ Leavenworth & Out of State

I am a tobacco user: ☐ Yes ☐ No

COMPANY BENEFITS

☐ **I ELECT MEDICAL BENEFITS** under BCC Level 1 Employee Health Care Plan for**:**
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

☐ **I DECLINE MEDICAL BENEFITS** under the BCC Level 1 Employee Health Care Plan because:
- ☐ I am covered as a dependent by another plan
  I am covered under TriCare
- ☐ Spouse/children are covered by another plan
- ☐ Myself or spouse is enrolled in Medicare
- ☐ Other:_____

☐ **I ELECT DENTAL BENEFITS** for:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

☐ **I DECLINE DENTAL BENEFITS**:
- ☐ I am covered as a dependent by another plan
- ☐ Spouse/children are covered by another plan
- ☐ Other

☐ **I ELECT VISION BENEFITS** for:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

☐ **I DECLINE VISION BENEFITS:**
- ☐ I am covered as a dependent by another plan
- ☐ Spouse/children are covered by another plan
- ☐ Other

ELIGIBLE DEPENDENT INFORMATION

For the following:

List all eligible dependents you want covered under this policy (spouse, children, step-children or children of legal guardianship). To add an alternative address for adult dependents, call 800-290-1368.
Unless handicapped, to qualify for coverage a child must be under the age of 26.

Dependent Name (first, mi, last)	***Social Security #*** ***Dependent social security numbers are mandatory for compliance with 42 U.S.C. 1395y(b)(7).***	**Gender M/F**	**Date of Birth**	**Relationship to Employee**

OTHER COVERAGE INFORMATION

Do you or any dependents applying for coverage have other group medical or dental insurance in effect now **that will not terminate upon this plan's effective coverage?** ☐ Yes ☐ No

If yes, please answer the following questions:

Type of Insurance: ☐ Group ☐ Individual ☐ Medicare ☐ Medicaid ☐ Other

Effective date of other coverage: _____ Other coverage includes: ☐ Medical ☐ Dental

Name of Policyholder: _____ Policy #: _____

Name of other Insurance Company: _____

Address: _____ City, ST, Zip : _____

Phone Number: _____

Identify each person insured _____

_____

I hereby acknowledge my receipt of the Notice of Privacy Practices.

I certify that I have selected the above plan option(s) and that I fully understand the terms and conditions of the plan(s). I further certify that the above listed information is true and correct. If I knowingly elect coverage for ineligible dependents, I understand and agree the Health Plan may seek to recover all paid claims. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance. I understand if my employment is terminated, upon re-employment, insurance will not be effective until I again apply for insurance in accordance with the terms of the group policy

I agree on behalf of myself and those family members enrolled ("Dependents") for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Benefit Management and their authorized representatives may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering health insurance benefits, including for treatment, payment or health care operations, as those terms are explained in detail in the Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness and substance abuse to the Health Plan for the Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I understand that if I choose to decline coverage, I waive the right to the Health Plan's coverage until the next open enrollment, unless my dependents or I experience a Special Enrollment qualifying event.

Employee Signature Date Print Name