



DISTRICT NAME: **Bullhead City S.D. #15** GROUP #: **24819**

**2026-2027
BENEFIT ENROLLMENT/
CHANGE FORM**

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
PRE-TAX Yes No (If Yes, must have Qualifying Event to make mid-year change)

EMPLOYEE INFORMATION – To be completed by the employee only					
LAST NAME		FIRST NAME		MI	DATE OF BIRTH (MM/DD/YY) / /
SOCIAL SECURITY NO.	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner		STATUS OF MEMBER <input type="checkbox"/> Active Employee <input type="checkbox"/> Cobra	
HOURS WORKED PER WEEK	ADDRESS CHANGE <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME CHANGE <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, previous name? _____			
MAILING ADDRESS					
CITY				STATE	ZIP
HOME PHONE NUMBER			WORK PHONE NUMBER		
ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (i.e. Medicare, Tricare, spouse's plan)					
IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____					
TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____					
IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____					
ENTITLEMENT TO MEDICARE DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)					

**TO BE COMPLETED BY
HUMAN RESOURCES ONLY**
(if this section is not complete,
form will be returned to the district)

NEW HIRE
Hire Date ____/____/____
Effective Date ____/____/____

TERMINATION OF INSURANCE

CHANGE
Effective Date of Change ____/____/____
Date of Qualifying Event ____/____/____

ADD/TERM DEPENDENT(S)
Qualifying Event _____

LEAVE OF ABSENCE
Start Date ____/____/____

OPEN ENROLLMENT

RETIREE
Effective Date ____/____/____

SALARY \$ _____

HR INITIALS _____ DATE ____/____/____

DECLINATION OF ENROLLMENT	
<input type="checkbox"/> I WISH TO WAIVE COVERAGE Are you currently covered by other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMPLOYEE SIGNATURE	DATE / /

BENEFIT SELECTION				
<input type="checkbox"/> ACTIVE: CLASSIC GOLD	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE/PARTNER	<input type="checkbox"/> EMPLOYEE + CHILD(REN)	<input type="checkbox"/> EMPLOYEE + FAMILY
<input type="checkbox"/> ACTIVE: CLASSIC SILVER	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE/PARTNER	<input type="checkbox"/> EMPLOYEE + CHILD(REN)	<input type="checkbox"/> EMPLOYEE + FAMILY
<input type="checkbox"/> ACTIVE: HDHP A	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE/PARTNER	<input type="checkbox"/> EMPLOYEE + CHILD(REN)	<input type="checkbox"/> EMPLOYEE + FAMILY
<input type="checkbox"/> ACTIVE: DENTAL	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE/PARTNER	<input type="checkbox"/> EMPLOYEE + CHILD(REN)	<input type="checkbox"/> EMPLOYEE + FAMILY
<input type="checkbox"/> ACTIVE: VSP VISION	<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE + SPOUSE/PARTNER	<input type="checkbox"/> EMPLOYEE + CHILD(REN)	<input type="checkbox"/> EMPLOYEE + FAMILY

IMS MEXICO NETWORK- VOLUNTARY YES NO

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)							
<i>Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP).</i> If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances: a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.							
DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	DISABLED DEPENDENT*	FULL-TIME STUDENT**	MARRIED**
, ,			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
, ,			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
, ,			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
, ,			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
, ,			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

*If your child is mentally or physically disabled, please provide appropriate documentation.
**Please note: You must check YES or NO for the Married and Full-Time Student columns above if enrolling in ASBAIT dental and/or vision benefits.

DISTRICT NAME: Bullhead City S.D. #15

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

IS YOUR SPOUSE EMPLOYED? YES NO IF YES, FULL TIME PART TIME SPOUSE EMPLOYER: _____ SPOUSE DATE OF BIRTH: ____ / ____ / ____

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL			__ / __ / __		
<input type="checkbox"/> PRESCRIPTION			__ / __ / __		
<input type="checkbox"/> DENTAL			__ / __ / __		
<input type="checkbox"/> VISION			__ / __ / __		

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? YES NO
EMPLOYER PROVIDING COVERAGE: _____ IF YES, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL			__ / __ / __			
<input type="checkbox"/> PRESCRIPTION			__ / __ / __			
<input type="checkbox"/> DENTAL			__ / __ / __			
<input type="checkbox"/> VISION			__ / __ / __			

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? YES NO IF YES, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IS MEDICARE COVERAGE DUE TO:
		__ / __ / __	__ / __ / __		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD
		__ / __ / __	__ / __ / __		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE
--------------------	---------------------	------