Western Area School Health Benefit Plan
Enrollment Directions

RED PLAN

All eligible employees should complete the attached applications for medical and voluntary life.

Employees may elect Dental and/or Vision if they are enrolled in the Medical Plan. The Dental and Vision elections can be at a different level than the Medical benefit. For example, an employee may have employee +2 Medical coverage, employee + 3/more Dental coverage and employee only Vision coverage.

Reminder – All eligible employees should complete the voluntary life insurance application. To accept or decline the coverage, the application that is included must be completed.

<u>HealthLink/HFN CHC Elite</u>
WASHBP utilizes HealthLink as the primary PPO network and HealthLink does not have direct contracts with OSF providers. Members will have access to OSF providers by utilizing a PPO network called HFN CHC Elite in Knox, Peoria and Tazewell counties in IL.

A plan participant must elect either the HealthLink PPO or the HFN PPO.

If you elect HealthLink as your PPO network, most OSF providers will be considered out of network providers, no matter their location.

If HFN network is selected, then the HealthLink website should not be used when searching for providers within Knox, Peoria or Tazewell counties. Only providers within the HFN network will be in-network in these counties. If they are not in the HFN network, then they would be considered out of network providers.

Directions on how to look up your provider can be found at www.washbp.com → PPO.

Q. When would it be a good idea to elect HealthLink as your PPO?
A. If your providers of choice are not in the HFN network in Knox, Peoria, and Tazewell counties.

Q. When would it be a good idea to elect HFN as your PPO?
A. If the majority of providers of choice are in Knox, Peoria and Tazewell counties and are in the HFN network, which includes most OSF providers.

EMPLOYEE REQUEST FOR GROUP COVERAGE

SECTION A: EMPLOYER INFORMATION

WESTERN AREA SCHOOL HEALTH BENEFIT PLAN

RED PLAN

Name of School: ________________________________

School Location Code: _____________

Office Use Only:
❑ **New Enrollment**
Date of Hire ___________________
Effective Date/First Day of Work ________________
❑ As defined by 26 USC 4980H(c)(4)
Effective Date ___________________

Original must be mailed to Consociate.

SECTION B: EMPLOYEE INFORMATION

Last Name	First Name	MI	
Address	City	State	Zip Code

Date of Birth	Sex	Social Security Number	Marital Status ❑ Single ❑ Married
Home Phone ( )		Business Phone ( )	Job Title ❑ Support Staff ❑ Certified Staff

SECTION C: ELECTION FOR BASIC LIFE AND AD&D COVERAGE

Basic Employee Life	Basic Dependent Life (if applicable)	Basic Dependent Life (if applicable)
❑ Amount: ____________	❑ Spouse Amount: ____________	❑ Child(ren) ❑ Amount: ___________

SECTION D: ELECTION FOR MEDICAL COVERAGE

Medical/Prescription Drug Program ❑ Employee ❑ Employee +1 ❑ Employee +2 ❑ Employee +3/more

Deductible Option (choose only one, this applies to employee and dependents)

❑ $1,000 ❑ $2,000 ❑ HDHP $3,000

PPO Network Option ❑ HealthLink (default network) ❑ HFN CHC Elite (Knox, Peoria and Tazewell Counties)

SECTION E: ELECTION FOR DENTAL COVERAGE (Employee must be enrolled in medical plan to elect dental coverage)

❑ Employee ❑ Employee +1 ❑ Employee +2 ❑ Employee +3/more

SECTION F: ELECTION FOR VISION COVERAGE (Employee must be enrolled in medical plan to elect vision coverage)

❑ Employee ❑ Employee +1 ❑ Employee +2 ❑ Employee +3/more

SECTION G: LIST ALL FAMILY MEMBERS TO BE INCLUDED IN YOUR COVERAGE

This includes medical, dental and/or vision coverage.

	Name Last, First, MI	**Date of Birth MM/DD/YYYY**	**Sex M/F**	**SS#**	**Relationship to the Insured** Natural Child	Step Child	Legally Adopted	Other
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								

SECTION H: OTHER COVERAGE INFORMATION

Do you have any physically or mentally disabled dependents? ❑ Yes ❑ No If yes, please provide name:

Are you or your dependents eligible for Medicare? ❑ Yes ❑ No

Are any of the individuals for which you have requested coverage covered by other medical, dental or vision plans?

Medical? ❑ Yes ❑ No Dental? ❑ Yes ❑ No Vision ❑ Yes ❑ No

If yes, Name of Insurance Company ________________________________

List Dependents covered by other plan 1. _______________ 2. _________________ 3. __________________
4. _______________ 5. _________________ 6. __________________

Things You Should Know:

1. **AUTHORIZATION FOR PAYROLL DEDUCTION AND EMPLOYEE ACKNOWLEDGEMENT:** I hereby request the insurance indicated for myself and/or my dependents and hereby authorize my employer to make deductions from my earnings of any required contributions to apply toward the premiums for the insurance provided in the policy or group insurance issued to my employer. All information given by me on this form is true and complete. I have read and understand all the information included on this form. I understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

2. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I agree to the following terms for myself and my dependents: We authorize, if permitted by law, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol, or psychiatric histories and treatment, to the Plan Administrators or their representatives. The Plan Administrators and their representatives may share such information and provide it to other insurers and claims administrators only for the purpose of administrating group coverage and claims for benefits, utilization review, provider peer review and the resolution of grievances. This authorization shall be valid for the term of coverage. I acknowledge that I have obtained a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original.

3. **WAIVER OF COVERAGE:** This is to certify that I have been given an opportunity for coverage available to me and my family members through my employer and I have decided to waive my right to coverage at this time. I understand that I may later enroll for medical coverage or any other coverage, if in the presence of a family status change or at open enrollment. I have read and understand the following with regard to special enrollments. I understand that it is my responsibility to report to my employer any change in my family (or individual) status.

   Please indicate the type of coverage you are waiving:

   ❑ Medical//Drug Card
   ❑ Dental
   ❑ Vision

   Reason for waiving coverage:

   ❑ Other Group Medical Coverage ❑ Other Group Dental Coverage ❑ Other Group Vision Coverage

   ❑ Other: ________________________________

I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each dependent name as covered under the Medical Benefits plan is considered a "dependent" as defined in the plan.

Employee Signature ________________________________ Date ______________________________

Please return the completed form to the Insurance Representative/Bookkeeper at your School/Agency's central office.

LOCATION CODES

040	Beardstown	CUSD #15
003	Central	CUSD #3
007	Dallas	ESD #327
009	Fulton Co (Cuba)	CUSD #3
031	Havana	CUSD #126
041	Illini West	HSD #307
014	LaHarpe	CSD #347
016	Liberty	CUSD #2
017	Mendon	CUSD #4

039	Midwest Central	CUSD #191
033	Payson	CUSD #1
019	Pikeland	CUSD #10
020	Pleasant Hill	CUSD #3
050	Regional Office of Ed	#1
051	Regional Office of Ed	#26
052	Regional Office of Ed	#33
053	Regional Office of Ed	#53
037	Schuyler-Industry	CUSD #5

025	Southeastern	CUSD #337
027	Spoon River Valley	CUSD #4
028	VIT	CUSD #2
029	West Central IL Special Ed Coop	
035	West Prairie	CUSD #103
010	Western Area Career System	

Revised 11/2019

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Designation of Beneficiary

Policyholder	Policy Number(s)
Insured Name	Social Security Number

I hereby designate the following as my beneficiary (ies) under the above policy number(s):
Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured

Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Heath form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

ARKANSAS and LOUISIANA — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **COLORADO** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK** (health insurance only) — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **OHIO** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PENNSYLVANIA** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE**, **VIRGINIA, 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 may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Home Office: Schaumburg, Illinois
Administrative Office: Philadelphia, Pennsylvania