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.

HealthLink/HFN CHC Elite

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 → RESOURCES → PROVIDERS.

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 many providers of choice are in the HFN network in Knox, Peoria and Tazewell counties, 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 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 (*See Section G)

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

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

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

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

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

SECTION F: 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 G: 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

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	

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Trustees of Western Area School Employee Benefits Trust		Effective Date:	Group ID: G000BXYB
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:			
*City:	*State:	*Zip Code:	

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Monthly Premium Amount
Voluntary Life and AD&D - Employee	☐ $10,000 ☐ $70,000 ☐ $130,000 ☐ $200,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Spouse	☐ $5,000 ☐ $20,000 ☐ $35,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child) ☐ Decline	$2.00 (all children)

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $200,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $35,000. In no event shall your amount of insurance exceed 5 times your salary.

- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.(Maximum of $10,000)
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount. (Maximum of $150,000)
- You must be less than age 80 for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 80.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information

Fraud Warning: 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. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*