EMPLOYEE ENROLLMENT APPLICATION & CHANGE FORM

Your OSBA application & change form is inside. It is essential that you read it carefully and complete all the necessary sections.

If you are a new enrollee:
a) applying for health coverage, please complete sections A-F.
If there is no other coverage, section E can be skipped.

b) waiving coverage, please complete section A & G.

If you are adding dependent(s):
a) complete sections A, B, D, E and F.
If there is no other coverage, section E can be skipped.

If you are dropping coverage or dependent(s):
a) complete sections A, B, C, D and F.

Documentation is Required for all Qualifying Events

When adding or dropping coverage or dependents due to a qualifying event, documentation is required to prove eligibility. See the attached Qualifying Event Guide on page 5. This documenation must be provided to and retained by your Payroll/Benefits Administrator.

Please return to your District Payroll Administrator for processing.

Please Return Pages 2-4 of this form.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section F.

**Note: You may be required to supply additional information.*

Thank you for choosing OSBA!

Ozarks Schools Benefits Association

Application for Insurance & Change Form

School District: ______________________________

OSBA Options PRIVATE EXCHANGE

Section A: Applicant Information

Legal Name (Last, First, MI):			Maiden Name (If Name Change is Being Requested):	
Social Security #:	Birth Date:		Gender: M F	Tobacco Use: Y N
Residential Address:				
City:	County:	State:		Zip:
Mailing Address (If Different from Residential):				
City:	County:	State:		Zip:
Primary Phone:	Secondary Phone:			
Email Address:				
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Occupation:	Full Time Hire Date:	Employee Status: ☐ Active ☐ Retiree ☐ Retiree Spouse		Hrs/Week

Section B: Application Information

☐ Open Enrollment ☐ Qualifying Event ☐ Address/Name Change
☐ New Hire ☐ Add/Drop Dependent ☐ Cancel Employee Coverage
☐ New Enrollment

Date of Qualifying Event: / /

Type of Qualifying Event (choose one):

☐ Marriage ☐ Divorce ☐ Newborn/Adoption ☐ Loss of Other Coverage
☐ Obtained Other Coverage ☐ Other:

***Qualifying Events require documentation to secure coverage.**

Section C: Coverage Options **See benefit summaries and rate sheets for plan specifics.**

Requested Effective Date *Month:* *Day:* *Year:*

Request Applies Toward ☐ *Medical* ☐ *Dental* ☐ *Vision* ☐ *All*

MEDICAL

☐ $1000/$1500/20% PPO
☐ $1500/$2000/30% PPO
☐ $2000/$2500/30% PPO
☐ $3000/3500/30% PPO
☐ $3000/$3500/100% HSA
☐ $4500/$5000/20% HSA
☐ $5000/$6000/20% HSA
☐ $6500/$7000/20% HSA

Coverage Level:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + 1 Child
☐ Employee + Children
☐ Family

DENTAL

☐ High Plan
☐ Low Plan

Coverage Level:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

VISION

☐ Platinum Plan/Dynamic Select Pl

Coverage Level:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

Section D: Dependent Information

Please complete for all dependents applying for coverage. If your dependent(s) is 26 years of age or older and handicapped, please provide documentation of this status.

Change Requested	Legal Name (Last, First, Middle)	Relationship	Social Security #	Gender	Birth Date mm/dd/yy	Tobacco Use
☐ Add ☐ Drop		***Spouse***		**M F**		**Y N**
☐ Add ☐ Drop		*Child*		**M F**		**Y N**
☐ Add ☐ Drop		*Child*		**M F**		**Y N**
☐ Add ☐ Drop		*Child*		**M F**		**Y N**
☐ Add ☐ Drop		*Child*		**M F**		**Y N**
☐ Add ☐ Drop		*Child*		**M F**		**Y N**

Employee Name:

Narrative (If Applicable):

Section E: Other Health Coverage

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the Insurance Company.		Policy/Certificate #	Eff. Date / /
Policy/Certificate Holder's Name	Social Security #	Date of Birth / /	Relationship to the Applicant

If you and/or your dependents are enrolled in Medicare, complete the following.

Enrollee's Name	Medicare ID #	Part A Eff. Date / /	Part B Eff. Date / /	ESRD Onset Date / /
___Age ___Disability ___ESRD & Disability ___End Stage Retinal Disease (ESRD)				
Enrollee's Name	Medicare ID #	Part A Eff. Date / /	Part B Eff. Date / /	ESRD Onset Date / /
___Age ___Disability ___ESRD & Disability ___End Stage Retinal Disease (ESRD)				

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my OSBA Benefit Program &/or its carriers.
2. I authorize deduction from my wages/pension, if necessary, for the required premium for the coverage for which I, or any dependents, have applied.
3. I am applying for the covrage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, OSBA reserves the right to accept or decline this application (and any insurance carrier(s), which underwrites any coverages, may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage if approved, may exclude coverage for pre-existing conditions. (Unless I applied for HMO/POS coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone converstion between OBSA and any insurance carriers providing benefit plans on behalf of OBSA and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by OSBA in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to covarage or premium rates. Any material misrepresentation or signigicant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s). I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your coverage will be provided by one of the following companies:

Ozarks Schools Benefits Association (OSBA) Health Plan Trust, Healthy Alliance Life Insurance Company for PPO, HMO Missouri, Inc for HMO, and for POS both Healthy Alliance Life Insurance Company and HMO Missouri, Inc.

Thank you for choosing OSBA!

Section F. Read the TERMS section carefully before signing. Please review your application for errors or ommissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date / /

Employee Name:

Section G. Waiver of coverage for employee and/or any eligible dependent not enrolling.

MEDICAL coverage declined for - Check all that apply:

☐ Myself ☐ Spouse ☐ Dependent(s)

DENTAL coverage declined for - Check all that apply:

☐ Myself ☐ Spouse ☐ Dependent(s)

VISION coverage declined for - Check all that apply:

☐ Myself ☐ Spouse ☐ Dependent(s)

Reason for declining coverage:

☐ Covered by spouse's group plan.
☐ Enrolled in individual coverage.
☐ Enrolled in Medicare.
☐ No coverage.
☐ Other:

By signing this form, I acknowledge that I have been offered coverage and am declining for the parties/plans indicated above.

Applicant Signature	Date
	/ /

HR/Employer Authorization

By signing this application, I agree that I have collected the necessary documents to prove that a qualifying event has occurred, if necessary. I understand that to complete the processing of this application, I might be required to provide these documents to the plan.

Payroll/Benefits Administrator Name	Payroll/Benefits Administrator Signature	Date
		/ /

QUALIFYING EVENT GUIDE

Individuals can only obtain/make changes to covearge outside of Open Enrollment if they have experience a Qualifying Event listed below.

·Newborn and adopted dependents are effective the date of birth or date of adoption.

·The application must be received by the plan no later than 30 days following the qualifying event date.

·Court ordered coverage will be effective on the date of the court order documentation.

·Dependents who have qualified for other coverage will be dropped as of the day their new coverage begins.

·Dependents who have lost other coverage will be added as of the day their previous coverage ended.

Qualifying Event	Description	Documentation Required
Termination of Employment	Termination of Employment applies to losing coverage due to resigning from a position or being terminated by an employer.	Letter from pervious employer stating termination date, last date of group insurance coverage, names of employee and all covered dependents, employer contact name and title, signed by administrator/owner on company letterhead or COBRA notification OR Employer Documentation Form.
Exhaustion of COBRA	Once COBRA runs out it is a Qualifying Event. Voluntarily dropping COBRA is not.	Letter stating exhaustion of COBRA, date COBRA ends and all affected members.
Employer No Longer Offers Group Coverage	If an employer decides to stop offering group coverage the currently covered employees/dependents have a Qualifying Event.	Letter from pervious employer stating termination date, last date of group insurance coverage, names of employee and all covered dependents, employer contact name and title, signed by administrator/owner on company letterhead or COBRA notification OR Employer Documentation Form.
Status Change/Reduction of Hours	An employee is moving from Full-Time to Part-Time or PRN and is no longer eligible for group coverage.	Letter from employer stating date of status change/reduction of hours, if employee is still eligible for group insurance coverage, last date of group insurance coverage, names of all dependents affected, signed by administrator/owner on company letterhead OR Employer Documentation Form.
Marriage	Getting married is a Qualifying Event.	Copy of Marriage Certificate with Seal or documenation showing Marriage Certificate was filed in court.
Birth/Adoption	Having a baby or adopting a child is a Qualifying Event for the new dependent(s) and the parents.	Birth: Application will provide the date of birth. Adoption: Adoption documentation showing date of adoption.
Divorce/Legal Separation	A divorce or legal separation provides the employee the opportunity to drop their ex-spouse from their coverage.	Complete Dissolution of Marriage including Judge's/Commissioner's signature.

Documentation must be submitted to your Payroll/Benefits Administrator with your application.

If you are experiencing an event outside of any of the ones listed above, please contact Capstone Insurors at 417.777.7570. Your event will be evaluated and we will advise if you are eligible for enrollment or changes. The events listed above are the most frequently experienced events. There are others that could apply.