Print Form

TRI-COUNTY SCHOOLS INSURANCE GROUP

ENROLLMENT/CHANGE FORM *TYPE OF CHANGE -* ☐ CLASS ☐ADDRESS /PHONE/ NAME ☐ ADD DEPENDENT ☐ PLAN ☐ BENEFICIARY

EMPLOYER NAME: Glenn County Office of Education	☐ NEW ENROLLMENT ☐OPEN ENROLLMENT (Entire Form Must Be Completely Filled Out)	EFFECTIVE DATE	DATE OF HIRE	☐ Full-Time ☐ Part-Time
SOCIAL SECURITY NO.	LOCATION NO. 220	CLASS NO.	EMPLOYEE JOB TITLE	
EMPLOYEE NAME LAST, FIRST, MI			DATE OF BIRTH	☐ Male ☐ Female
EMPLOYEE MAILING ADDDRESS	City	State	Zip	☐ Single ☐ Married or DP ☐ Divorced ☐ Widowed
HOME PHONE	WORK PHONE	*(OPTIONAL)* * EMAIL ADDRESS FOR TCSIG COMMUNICATIONS		
SPOUSE'S EMPLOYER NAME AND ADDRESS				
IF SPOUSE IS ENROLLED IN ANOTHER PLAN PLEASE PROVIDE INSURANCE COMPANY NAME:			PLAN NUMBER:	

COMPLETE THIS SECTION ONLY IF DEPENDENT COVERAGE IS ELECTED

Please list all eligible family members to be enrolled or changed. New Enrollees must provide a copy of their **Marriage Certificate** or **Certificate of Domestic Partnership** when electing spousal coverage. A copy of the child(ren)'s **Birth Certificate** is required when electing dependent coverage.

NAME	SEX		DATE OF BIRTH			SOCIAL SECURITY NO.	Other insurance coverage?	
LAST, FIRST, MI	M	F	MM	DD	Year		Yes	No
Spouse	☐	☐					☐	☐
Child	☐	☐					☐	☐
Child	☐	☐					☐	☐
Child	☐	☐					☐	☐
Child	☐	☐					☐	☐

If the answer to Other Insurance Coverage for Child(ren) is yes, please complete the following:

Name of Policy Holder: _____ Name of Insurance Company: _____

Plan Name or Number: _____ Relationship to Policy Holder: _____

COVERAGE ELECTION

TYPE OF COVERAGE	PLAN NAME OR NUMBER	EMPLOYEE	SPOUSE	CHILD	EFFECTIVE DATE
MEDICAL	SELECT PLAN	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
DENTAL	D3	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
VISION	C	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Fill in if your employer offers Life Insurance through TCSIG. The carrier is ReliaStar Life Insurance Company, a member of the Voya Financial® family of companies and the Policy Number is 67999-2

BENEFICIARY INFORMATION FOR LIFE/AD&D COVERAGE:

If the Primary Beneficiary(ies) dies before me, I designate as the Contingent Beneficiary(ies): I RESERVE the right to change this designation at any time.

PRIMARY BENEFICIARY: Last Name, First, MI Relationship DOB

Address

City State Zip

Social Security Number Phone Number

CONTINGENT BENEFICIARY: Last Name, First, MI Relationship DOB

Address

City State Zip

Social Security Number Phone Number

Unless designated otherwise, payment will be made in equal shares or all to the survivor. Indicate how benefits are to be designated (e.g., Divide equally among beneficiaries).

PARTICIPANT DECLARATION: I declare that the above answers are true to the best of my knowledge and I have read and understand the Participant Authorization on the back of this form. I hereby authorize my Employer to deduct from my earnings any required contributions for the cost of benefits for which I am or may become eligible.

Signature Date

WAIVER OF BENEFITS: I hereby certify the benefits provided under the Group Medical Insurance program as provided by my Employer have been explained to me. I have been given an opportunity to participate in all of the plans offered and I voluntarily decline to do so. I understand by refusing to participate in the plans, I surrender any rights I may have had to cover my dependents and myself. Should I wish to become covered at a later time, I understand I must wait until the next open enrollment period offered by my Employer and Tri-County Schools Insurance Group.

Signature Date

PERSONAL HEALTH INFORMATION (PHI)

Any information provided on this Enrollment Form will only be used for communication with the Covered Person, claims processing and benefit management.

PARTICIPANT AUTHORIZATION:

I understand I am applying to Tri-County Schools Insurance Group (TCSIG) for coverage for myself and my dependents, if any, as shown on this form. I understand any misstatements on this form may be used as a basis for recision of benefits for me and my dependents (if any) from the effective date. I further understand that if the benefits applied for become effective, I will be subject to all of the terms of the group policy(ies). I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, or other organization, employees, or other person that has any information available as to my health or that of any member of my family covered under this Plan to give TCSIG or its legal representative any such information. A photographic copy of this authorization shall be as valid as the original.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may subject such person to criminal and civil penalties.

NOTICE:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

*** EMAIL NOTICE**

Privacy is important to us; therefore, we will not sell, rent, or give your name or email address to anyone. Once you're signed up, you will receive periodic emails that we hope you find interesting and helpful. At any point, you can select the link at the bottom of every email to unsubscribe**.**

_____ _____

Signature Date