Karns City Area School District
Open Enrollment Application

Part 1 of 2:
Detailed Employee Information:

As part of the annual renewal or enrollment of your insurance coverage options, open enrollment is required, but also permits you to make changes to your existing medical, vision and dental insurance coverage. **This form is mandatory for all employees to complete for the upcoming fiscal year 2019-2020 (July 1, 2019 – June 30, 2020)**.

This form will need to be completed and submitted to the District Office by all staff **no later than Friday, June 7, 2019**. The prompt and timely completion of the open enrollment application will aid in ensuring that your appropriate coverage options have been selected. **Please be advised that it is the employee's responsibility to notify the District Office should there be a change in coverage status throughout the upcoming fiscal year.** This could include changes such as the addition or deletion of dependents as a result of marriage, birth or change in education enrollment status.

Employee Information: Please identify the following basic employee information.

Employee Name	Employee Social Security #	Employee Date of Birth

The Karns City Area School District offers two medical insurance provider options, with identical plan options, with the exception of varying in-network service providers. Please select which medical insurance provider you would prefer as acknowledged by a "✓".

UPMC: _____ **Highmark:** _____

Coverage Selections: Please indicate the type of coverage you are to be enrolled in based upon your family status. Please refer to Part 2 of 2 for a description of eligible dependents. Please make selections as acknowledge by a "✓". If you do not wish to participate in a certain coverage option, please indicate by using the word "Waive."

	Medical	Vision	Dental
Single			
Employee & Child(ren)			
Employee & Spouse			
Family			

What Next?

(1) If all insurance options above are "✓" Single, please sign and submit this form to the District Office.
(2) If any of your above insurance selections include dependents, such as Employee & Child(ren), Employee & Spouse, or Family, please complete Part 2 of 2, and then sign and submit this form.
(3) If you elected to Waive medical coverage, please complete and sign a Waiver explaining that you understand you will not be covered by medical insurance through KCASD for fiscal year 2019-2020.

Please keep a copy for your records.

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Part 2 of 2

Detailed Dependent Information:

Dependent Information: Please identify the following dependent information in the grid provided. In order for dependents to be enrolled, **all** information requested must be included. If your dependent is eligible please acknowledge with a "✓" in the appropriate box. If they are not eligible for certain insurance coverage, please indicate with a "N/A." See the notes below for eligibility.

Dependent Information				Coverage		
	Name	Date of Birth	Social Security #	Medical	Vision	Dental
Spouse:						
Child(ren):						

Full Time Student Information: If your dependent(s) are a full time student at an accredited learning institution, please complete the following table. In order for dependents to be enrolled, **all** information requested must be included.

Dependent Name	Accredited Learning Institution	Grade Level

Is My Dependent Eligible for Coverage?

Medical – Your spouse is eligible if they are not covered by Medicare. Your child is eligible if you are the legal guardian and they are under age twenty-six (26). Student enrollment status is not needed for Medical Coverage as a result of the Affordable Care Act. This means that dependents are covered under medical insurance until age twenty-six (26), unless covered by under another insurance plan.

Vision/Dental – Your spouse is eligible if they are not covered by Medicare. Your child is eligible until eighteen (18) if you are the legal guardian. Your child will also remain eligible until age twenty-three (23) if they are enrolled full time in an accredited institution. Their eligibility will terminate at the earlier of either (a) graduation from an accredited learning institution, or (b) they reach age twenty-three (23).

In order to remain enrolled in Vision and/or Dental coverage, full time student status must be verified every semester until graduation.

I certify that the information submitted in this application is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Please keep a copy for your records.