****ESPA NEW HIRE ONLY ****

ENROLLMENT EFFECTIVE DATE: _____

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME

DIVISION: ☒ HAESPA

DATE OF HIRE: _____ **JOB TITLE:** _____ **GROUP NUMBER:** _____

EMPLOYEE:

PLEASE PRINT CLEARLY TO AVOID ERRORS

ARE YOU CURRENTLY ENROLLED IN INSURANCE WITH THE DISTRICT THROUGH A SPOUSE OR PARENT? ☐ YES ☐ NO

IF SO, WHICH PLANS ARE YOU CURRENTLY ENROLLED IN AS A DEPENDENT? ☐ HEALTH ☐ DENTAL ☐ VISION

DUE TO THE PATRIOT ACT, EMPLOYEE'S ADDRESS MUST BE EXACT TO WHAT APPEARS ON YOUR DRIVER'S LICENSE OR STATE ISSUED ID

FIRST: _____ ADDRESS: _____

MI: _____ ADDRESS 2: _____ DATE OF BIRTH: _____

LAST: _____ CITY: _____ SOCIAL SECURITY NUMBER: _____

STATE: _____ ZIP: _____ ANNUAL SALARY: _____

GENDER: ☐ MALE ☐ FEMALE PHONE NUMBER: _____ EMAIL ADDRESS: _____

PLEASE SELECT THE PLAN & TIER BELOW THAT IS APPLICABLE TO YOU:

MEDICAL/RX: HIGHMARK/CVS	☐ PERFORMANCE FLEX BLUE $2,000/$4,000 WITH HSA	☐ SINGLE	☐ EMPLOYEE + 1	☐ EMPLOYEE + 2 OR MORE	☐ WAIVING
MEDICAL/RX: HIGHMARK/CVS	☐ PERFORMANCE FLEX BLUE $500/$1,500	☐ SINGLE	☐ EMPLOYEE + 1	☐ EMPLOYEE + 2 OR MORE	☐ WAIVING
DENTAL: UNITED CONCORDIA	☐ SUB-DIVISION #:	☐ SINGLE	☐ EMPLOYEE + 1	☐ EMPLOYEE + 2 OR MORE	☐ WAIVING
VISION: N V A (NAT'L VISION)	☐ 12/24/12 PLAN SUB-DIVISION #:	☐ SINGLE	☐ EMPLOYEE + 1	☐ EMPLOYEE + 2 OR MORE	☐ WAIVING
VOLUNTARY LIFE & AD&D:	☐ MUTUAL OF OMAHA	☐ ENROLL	☐ WAIVING		

PLEASE ENTER APPLICABLE SPOUSE INFORMATION:

☐ ADD COVERAGE FOR SPOUSE:

☐ MEDICAL NAME: _____ ADDRESS: _____ DATE OF BIRTH: _____

☐ DENTAL CITY: _____ SOCIAL SECURITY NUMBER: _____

☐ VISION STATE: _____ ZIP: _____ GENDER: ☐ MALE ☐ FEMALE

PLEASE ENTER APPLICABLE CHILD INFORMATION:

☐ ADD COVERAGE FOR CHILD:

☐ MEDICAL NAME: _____ ADDRESS: _____ DATE OF BIRTH: _____

☐ DENTAL CITY: _____ SOCIAL SECURITY NUMBER: _____

☐ VISION STATE: _____ ZIP: _____ GENDER: ☐ MALE ☐ FEMALE

PLEASE ENTER APPLICABLE CHILD INFORMATION:

☐ ADD COVERAGE FOR CHILD:

☐ MEDICAL NAME: _____ ADDRESS: _____ DATE OF BIRTH: _____

☐ DENTAL CITY: _____ SOCIAL SECURITY NUMBER: _____

☐ VISION STATE: _____ ZIP: _____ GENDER: ☐ MALE ☐ FEMALE

PLEASE ENTER APPLICABLE CHILD INFORMATION:

☐ ADD COVERAGE FOR CHILD:

☐ MEDICAL NAME: ____________ ADDRESS: ____________ DATE OF BIRTH: ____________
☐ DENTAL CITY: ____________ SOCIAL SECURITY NUMBER: ____________
☐ VISION STATE: ______ ZIP: ____________ GENDER: ☐ MALE ☐ FEMALE

PLEASE ENTER APPLICABLE CHILD INFORMATION:

☐ ADD COVERAGE FOR CHILD:

☐ MEDICAL NAME: ____________ ADDRESS: ____________ DATE OF BIRTH: ____________
☐ DENTAL CITY: ____________ SOCIAL SECURITY NUMBER: ____________
☐ VISION STATE: ______ ZIP: ____________ GENDER: ☐ MALE ☐ FEMALE

PLEASE ENTER APPLICABLE CHILD INFORMATION:

☐ ADD COVERAGE FOR CHILD:

☐ MEDICAL NAME: ____________ ADDRESS: ____________ DATE OF BIRTH: ____________
☐ DENTAL CITY: ____________ SOCIAL SECURITY NUMBER: ____________
☐ VISION STATE: ______ ZIP: ____________ GENDER: ☐ MALE ☐ FEMALE

STATEMENT OF APPLICATION:

I HEREBY APPLY FOR THE COVERAGE INDICATED. I UNDERSTAND THIS APPLICATION IS SUBJECT TO APPROVAL BY THE CARRIER, ITS SUBSIDIARIES, AND/OR REINSURERS, AND ANY COVERAGE PROVIDED WILL BE SUBJECT TO THE TERMS OF THE AGREEMENT AND/OR CONTRACTS ISSUED TO ME. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. I VERIFY THAT THE INFORMATION SUPPLIED BY ME IS CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

I HEREBY AUTHORIZE PARTICIPATION AND DIRECT MY EMPLOYER TO REDUCE MY SALARY IN THE AMOUNT NECESSARY TO PAY FOR THE BENEFIT COVERAGES LISTED ABOVE AND UNDERSTAND THAT THIS AMOUNT WILL NOT BE SUBJECT TO SOCIAL SECURITY OR FEDERAL INCOME TAX WITHHOLDING, WHICH MAY RESULT IN A REDUCTION OF FUTURE SOCIAL SECURITY BENEFITS TO WHICH I MAY BE ENTITLED. SUCH REDUCTIONS, CONSIDERED AS ELECTIVE CONTRIBUTIONS UNDER THE PLAN, WILL START WITH MY FIRST PAYCHECK DATED AFTER THE EFFECTIVE DATE THE PLAN. I FURTHER AUTHORIZE FUTURE ADJUSTMENTS IN THE AMOUNT OF THE SALARY REDUCTION IN THE EVENT THE COST OF COVERAGE IN ANY PROGRAM SELECTED IS CHANGED BY THE CARRIER DURING THE PLAN YEAR. I ALSO UNDERSTAND THAT THE PURPOSE OF THIS PROGRAM IS TO ALLOW EMPLOYEES TO SELECT THEIR QUALIFIED BENEFITS WITHIN THE GUIDELINES OF THE INTERNAL REVENUE CODE. I UNDERSTAND THAT THE SELECTION OF A BENEFIT AND THE INDICATION THAT A PREMIUM IS TO BE PAID DOES NOT NECESSARILY INCLUDE ME IN THE INSURANCE PORTIONS OF THIS PLAN. IN MOST INSTANCES AN APPLICATION FOR INSURANCE MUST ALSO BE COMPLETED. I AM AWARE THAT ONCE I HAVE ELECTED TO PARTICIPATE IN THIS PLAN THAT I MAY NOT REVOKE MY ELECTION UNTIL THE END OF THE PLAN YEAR WITH THE EXCEPTION OF A CHANGE IN FAMILY STATUS.

THIS ELECTION FORM WILL REMAIN IN EFFECT AND CANNOT BE REVOKED OR CHANGED DURING THE PLAN YEAR, UNLESS REVOCATION AND A NEW ELECTION ARE ON ACCOUNT OF AND CONSISTENT WITH A CHANGE IN FAMILY STATUS.

WAIVER OF BENEFITS:

☐ I AM ELECTING TO WAIVE BENEFITS AVAILABLE THROUGH HAZLETON AREA SCHOOL DISTRICT AND UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN MEDICAL COVERAGE.

____________________	____________________	____________
EMPLOYEE SIGNATURE	**EMPLOYEE NAME (PLEASE PRINT)**	**DATE**

OFFICE USE ONLY: PRO-RATED: ____________ BI-WEEKLY HSA PAYROLL DEDUCTION: ____________