# Health Insurance Waiver and Special Enrollment Information

**Employee Name: _______________________________________ID#:______________________**

**I, ________________________________________, have other health insurance coverage. Therefore, I have decided to waive health insurance coverage as a new hire with Pensacola State College and elect the Dental and Vision (DV) alternate plan.**

**Name of Current Health Insurance Carrier: __________________________________________**

☐ **Individual** ☐ **Medicare/Medicaid** ☐ **TRICARE**

☐ **Spouse Employer-Sponsored Group Plan** ☐ **COBRA**

## Enrollment Rights and Certification – Please sign after carefully reviewing:

By signing below, I certify that Pensacola State College has given me the opportunity to sign up for health insurance coverage for myself and my eligible dependents, if any, within 30 days of my hire date. I certify that I have health coverage elsewhere. Therefore, I am declining Pensacola State College's health insurance coverage for myself and any eligible dependents.

I understand that I may be eligible to enroll in the health insurance coverage if for any reason I, and eligible dependents, lose health insurance coverage with the prior carrier. However, I must request enrollment within 30 days after my prior health insurance coverage ends and submit a change in status request with supporting documentation of the loss of coverage, per enrollment procedures.

In addition, I also understand if a qualifying event occurs due to a life change status event election, I must inform and submit any supporting documentation to the Human Resources Department within 30 days of the event in order to make any relevant changes to my health insurance benefits. Qualifying life status change events include marriage, divorce, legal separation, marriage annulment, birth, adoption, legal custody, placement for adoption, change in employment, loss of health coverage, change in work hours part-time / full-time, death of spouse or dependent, unpaid leave of absence, legal medical support court order, eligibility for Medicare or Medicaid, or dependent ceases to satisfy the dependent eligibility requirements.

I understand that plan changes during the year are not permitted, unless, there is a qualifying change in status or my health coverage ends with my prior insurance carrier. I can only submit plan changes during Pensacola State College annual open enrollment period.

I understand that I need to contact the Human Resources Department if I need more information on health insurance, benefits or special enrollment rights. HR: 484-1766 or Benefits: 850-484-1724.
I certify that the statements on this form are true and complete to the best of my knowledge and belief.

________________________________________________________________________

**Employee Signature** **HR/Benefits Representative Signature** **Date**

# DENTAL/VISION ENROLLMENT/CHANGE FORM

| Effective Date / / | Delta Group No.16020 |
| --- | --- |
| Full Time Hire Date / / | VSP Policy 30035956 |

## Check One
(**Enrollees can change plans only during open enrollment)

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Change Dental Plans**
- ❑ COBRA
- ❑ Add/Delete Dependent
- ❑ Terminate Employee Coverage
- ❑ Spouse Employment Change
- ❑ Marital Change
- ❑ Other ____________

Indicate qualifying date: (Month) (Day) (Year)

## COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce
- ❑ Widowed/Surviving Dependent
- ❑ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Delta Dental - 1-800-521-2651
www.deltadentalins.com

VSP Vision - 1-866-213-2249
www.vsp.com

## Primary Enrollee Information
VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First, Middle)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No.____________ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single ❑ Married ❑ Gender: Male ❑ Female ❑ Phone # ( ) —

Do you have dependent children? Yes ❑ No ❑ Are you or your dependents covered under another dental plan? Yes ❑ No ❑

## Dependent Information
(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

| | Add | Delete | Male | Female | Date of Birth: (Month) (Day) (Year) |
| --- | --- | --- | --- | --- | --- |
| Spouse: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |
| Dependent: | ❑ | ❑ | ❑ | ❑ | Date of Birth: |

Dentist Name: Provider # Location (State)

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

❑ I decline coverage at this time.

*Notice for Florida only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

Signature of Enrollee ____________________ Date ____________