Lee's Summit R-VII School District
2022 Insurance Change Form

The benefit options selected when you first become eligible and/or during the annual open enrollment will remain in effect throughout the calendar year unless you experience an eligible qualifying event (defined on Page 4). If you experience an eligible qualifying event during the calendar year, you may request changes to your insurance plans for yourself or eligible family members. (Please note: If you are adding family members mid-year, they must be added to the plan you are currently enrolled in. A mid-year change will not allow you to change plans.)

You do NOT have the option of selecting the effective date. Your change in coverage will be effective based upon your qualifying event date.

To request changes for yourself and/or eligible family members to your insurance plans mid-year, due to an eligible qualifying event, **all** of the following must be received in the Business Services Department at the Stansberry Leadership Center **within 31 calendar days of the qualifying event date.** (For gain or loss of Medicaid or Medicare, documentation must be provided within 60 calendar days of the qualifying event.) The change(s) you request must be consistent with the qualifying event.

1. Insurance Change form accurately completed and signed;
2. Appropriate documentation verifying the qualifying event (see Page 4 for acceptable documentation); **AND**
3. Additional premium due, if coverage is being added, paid by check (made payable to Lee's Summit R-VII School District) or cash. If requested, a receipt of payment will be provided to you.

If **ALL** of these items are not received within the above specified number of days, you will be unable to make a mid-year change and will have to wait until the next open enrollment period to make changes to your benefits.

For additional questions regarding mid-year changes, visit https://benefits.lsr7.org/life-changing-events/ or contact the Business Services Department at (816) 986-1000 or by email at Benefits@lsr7.net.

1. Your Information: **Name** _____

Work Location _____

Daytime Phone Number _____

2. Your Social Security Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

3. Qualifying Event: (please check mark event)

- ☐ Adoption, birth, or placement for adoption of child
- ☐ Employment status change for self, spouse or dependent
- ☐ Enrollment in a Federal Marketplace/Exchange plan
- ☐ Gain or loss of Medicaid or Medicare entitlement
- ☐ Guardianship of Child (full & legal)
- ☐ Other:_____
- ☐ Judgment, decree or order mandating alternative coverage for child
- ☐ Legal separation or divorce
- ☐ Loss of eligibility for other coverage
- ☐ Marriage
- ☐ Open Enrollment for spouse or dependent

4. Please list the individual(s) below in which a change in coverage is requested for:

Legal Name	Social Security Number*	Relation	Gender	Date of Birth	Medical (Please Circle One)	Dental (Please Circle One)	Vision (Please Circle One)
					Add Drop NA	Add Drop NA	Add Drop NA
					Add Drop NA	Add Drop NA	Add Drop NA
					Add Drop NA	Add Drop NA	Add Drop NA
					Add Drop NA	Add Drop NA	Add Drop NA

**For newborns only: change form may be submitted without the Social Security Number (SSN). Please contact Business Services with the SSN as soon as received.*

5. Please complete <u>ONLY</u> the following sections which relate to the change(s) you are requesting. All other coverage will remain as you have previously elected. <u>You MUST sign and date the final page</u>.

<u>Medical:</u> (Check the plan you are changing to. If you no longer want to participate in the medical plan, check "Waive Coverage.")

		Your Monthly Cost*
☐	Waive Coverage	NO INSURANCE GRANTED
☐	HMO – Employee Only	$103
☐	HMO – Employee & Spouse	$1,057
☐	HMO – Employee & Child(ren)	$794
☐	HMO – Family	$1,944
☐	EPO – Employee Only	$89
☐	EPO – Employee & Spouse	$1,031
☐	EPO – Employee & Child(ren)	$770
☐	EPO – Family	$1,906
☐	Preferred-Care Blue HDHP – Employee Only	$25
☐	Preferred-Care Blue HDHP – Employee & Spouse	$745
☐	Preferred-Care Blue HDHP – Employee & Child(ren)	$544
☐	Preferred-Care Blue HDHP – Family	$1,411
☐	Preferred-Care Blue HDHP – Special Family	$752
☐	BlueSelect Plus HDHP – Employee Only	$0
☐	BlueSelect Plus HDHP – Employee & Spouse	$659
☐	BlueSelect Plus HDHP – Employee & Child(ren)	$475
☐	BlueSelect Plus HDHP – Family	$1,269
☐	BlueSelect Plus HDHP – Special Family	$643

If you are enrolling in the HMO plan, a Primary Care Physician must be selected for each added member. *Please complete below.*

**These rates are based upon full time employment. For part-time costs, please contact Business Services.*

<u>For Preferred-Care Blue HDHP / BlueSelect Plus HDHP Enrollees</u>, the District's $149 *(Preferred-Care Blue)**/$182 *(BlueSelect Plus)** per month contribution should be deposited to (circle one): HSA HRA

If you are enrolling in the HMO plan, you will need to select a Primary Care Physician (PCP) for each covered member of your family. Please refer to the Blue Cross Blue Shield website (<u>www.bluekc.com</u>) for a listing of PCPs. To change an existing PCP, contact Blue Cross Blue Shield at (816) 395-3558.

Member's Name (include all covered dependents)	BCBS PCP Number

<u>Health Savings Account Election (for Preferred-Care Blue HDHP and BlueSelect Plus HDHP Enrollees):</u>
*(Elections will be deducted on a **PRE-TAX** basis, reducing the taxes you pay.)*

Do you wish to contribute additional money to your HSA (circle one)? Yes No

If participating, your annual contribution amount for 2022: $_____

For HDHP Enrollees, do you wish to contribute to a *Limited* FSA for dental and vision only (circle one)? Yes No

If participating, your annual contribution amount for 2022: $_____

<u>Dependent Life Elections:</u> (NOTE: Changes allowed only for birth, adoption, marriage or divorce)

Spouse Participating (Circle One) **Yes** or **No** *Amount of Coverage: $10,000; Monthly Cost: $1.40*

Child(ren) Participating (Circle One) **Yes** or **No** *Amount of Coverage: $10,000; Monthly Cost: $1.36*

Dental: (Check the plan that you are changing to. If you no longer want to participate in the dental plan, check "Waive Coverage.")

		Your Monthly Cost
☐	Waive Coverage	NO INSURANCE GRANTED
☐	Core Plan – Employee Only	$0
☐	Core Plan – Employee & Spouse	$11.82
☐	Core Plan – Employee & Child(ren)	$15.74
☐	Core Plan – Family	$30.30
☐	Basic Plan – Employee Only	$5.54
☐	Basic Plan – Employee & Spouse	$25.62
☐	Basic Plan – Employee & Child(ren)	$40.46
☐	Basic Plan – Family	$59.70
☐	Buy-Up Plan – Employee Only	$23.34
☐	Buy-Up Plan – Employee & Spouse	$60.48
☐	Buy-Up Plan – Employee & Child(ren)	$90.64
☐	Buy-Up Plan – Family	$125.64

If you are enrolling in the Core plan, a Primary Dentist must be selected for each added member. *Please complete below.*

If you are enrolling in the Core DHMO plan, you will need to select a Primary Dentist for each covered member of your family. Please refer to the Cigna website (www.cigna.com) for a listing of dentists. To change an existing Primary dentist, contact Cigna at (800) 244-6224.

Member's Name (include all covered dependents)	Cigna Dental Provider Number

Vision: (Check the plan that you are changing to. If you no longer want to participate in the vision plan, Check "Waive Coverage.")

		Your Monthly Cost
☐	Waive Coverage	NO INSURANCE GRANTED
☐	Basic Plan - Employee Only	$6.98
☐	Basic Plan - Employee & Spouse	$10.96
☐	Basic Plan - Employee & Child(ren)	$10.80
☐	Basic Plan - Family	$17.42
☐	Buy-Up Plan – Employee Only	$8.24
☐	Buy-Up Plan – Employee & Spouse	$12.92
☐	Buy-Up Plan – Employee & Child(ren)	$12.76
☐	Buy-Up Plan – Family	$20.56

6. By signing below, I certify a qualifying event has occurred within the past 31 calendar days and coverage will be effective based upon the date of my qualifying event.

Employee Signature: _____

Date: _____

7. These changes will be effective:_____ (to be completed by Business Services).

FOR DISTRICT OFFICE USE ONLY

Required Documentation Received

_____ Completed Form
_____ Documentation
_____ Premium, if applicable
Check # _____
Cash _____
Amount _____

Upon Receipt of ALL Documentation

_____ Date Case Mgmt Sent to CBIZ
_____ BusinessPlus Changes Made
Benefit Assignments_____
Family _____
Dependent Beneficiaries _____
_____ Reimbursement, if applicable

Based upon the type of qualifying event, please use the following chart to help determine the acceptable documentation, effective date of coverage and premium impact:

QUALIFYING EVENT	ACCEPTABLE DOCUMENTATION	EFFECTIVE DATE OF COVERAGE	PREMIUM IMPACT
Adoption or placement for adoption of child	Copy of finalized court documents indicating date of event.	**Earlier of:** (i) the moment of birth for a newborn child if a petition for adoption was filed within 31 days of the birth of the child; (ii) the date the petition for adoption was filed; or (iii) date of child's placement.**	Premium **is required** or reimbursed if the Qualifying Event date is **before** the 15th of the month. Premium **is not required** or will not be reimbursed if the Qualifying Event date is **on or after** the 15th of the month.
Birth of child	Birth certificate, Hospital Crib Card or Hospital invoice showing name and date of child's birth.	Date of Birth	
Employment Status Change *(reduction in hours or termination of employment resulting in end of insurance eligibility / new employment or increase in hours resulting in new insurance eligibility)*	If you, no forms required. If spouse or dependent, letter/form from spouse's or dependent's old or new employer indicating the gain or loss of employment. Letter/form must indicate coverage type(s), last date of coverage or first date coverage is available, and who was or will be covered.	First day following the date the other coverage terminates or day prior to the date coverage begins.	
Enrollment in a Federal Marketplace/Exchange plan	Copy of enrollment verification which indicates coverage start date.	Day prior to the date coverage begins.	
Gain or loss of Medicaid or Medicare entitlement	Letter/form indicating the gain or loss of coverage. Letter/form must indicate last date of coverage or first date coverage is available.	First day following the date the other coverage terminates or day prior to the date coverage begins.	
Guardianship of child (full and legal)	Copy of court order awarding full guardianship.	Date of legal guardianship as indicated in court documents.	
Judgment, decree, or order mandating alternative coverage for a child	Copy of medical support order or court documents.	Date indicated in medical support order or court documents.	
Legal Separation or Divorce	Self: Letter/form indicating the resulting loss of coverage. Letter/form must indicate last date of coverage.	First day following the date the other coverage terminates.	
	Spouse: Copy of finalized court documents indicating date of event.	Date of Divorce.	
	Child(ren): Copy of finalized court documents indicating date of event. If coverage is not court ordered, must supply a letter/form indicating the gain or loss of coverage. Letter/form must indicate last date of coverage or first date coverage is available.	First day following the date the other coverage terminates or day prior to the date coverage begins.	
Loss of Eligibility for Other Coverage ***	Letter/form indicating the date you, your spouse/dependent are no longer eligible and what type(s) of coverage is ending.	First day following the date the other coverage terminates or day prior to the date coverage begins..	
Marriage	Marriage certificate indicating both parties and date of marriage.	Date of the Marriage	
Open Enrollment for Spouse/Child	Letter from spouse's or dependent's employer indicating an open enrollment change. Letter must indicate coverage type(s), last date of coverage or first date coverage is available, and who was or will be covered.	First day following the date the other coverage terminates or day prior to the date coverage begins.	

***Date of placement means the date you assume the legal obligation for total or partial support of the child to be adopted in connection with formal adoption proceedings.*

****Loss of eligibility for coverage does NOT include termination of coverage due to untimely payment of premiums or termination for cause. Also, dropping or cancelling an individual insurance plan, is **NOT** an eligible qualifying event.*

Please note: A completed and signed Insurance Change form, acceptable documentation verifying the qualifying event date and additional premium due, if adding coverage, must be received in the Business Services Department *within 31 calendar days* of the qualifying event date in order to change your benefits mid-year. If the change form, documentation and premium, if adding coverage, are not received within 31 calendar days of the qualifying event date, you will have to wait until the next annual open enrollment period to make changes to your benefits. (For gain or loss of Medicaid or Medicare, documentation must be provided within 60 calendar days of the qualifying event.)