Coversheet for Health, Life & Dental Insurance

Please check one event below. This completed page must accompany benefit forms

____ I am a new employe OR I am an employee who is now eligible for health/life/dental

____ I have experienced a "Qualifying Event" such as change in marital status, the acquisition of a dependent or the loss of coverage through your spouse's plan. Contact Wellmark for detailed description of Qualified Event.

____ Open enrollment change in coverage - Form due May 26, coverage change July 1

First Name _____ Last Name _____ Middle Name _____

Address _____ Birthdate _____

City, State, Zip _____ Marital Status Single Married

Telephone _____ Soc. Sec. No. _____

Required coverage	Optional coverage
X Single Life Insurance $2.85	____ Single Health A - $645.15
X Single Dental $40.00	____ Single Health B - $513.15
	____ Single Health C - $497.15
	____ Family Dental - $66.48
	____ Family Life - $1.15
	____ Family Health A & Family Life $1607.15
	____ Family Health B & Family Life $1283.15
	____ Family Health C & Family Life $1239.15

$42.85 Required Coverage (Single Dental & Life Insurance)

\+ _____ Optional Coverage (total of optional coverage selected above)

= _____ Total of Required coverage and Optional Coverage

\- $600.00 Monthly Benefit - This is the maximum amount BHSSC will pay towards your elected insurance premiums.

= _____ Difference - This is the amount that will be deducted monthly from your paycheck. It will be spread out over two pay periods.

Wellmark. South Dakota

Wellmark Blue Cross and Blue Shield of South Dakota is an independent licensee of the Blue Cross and Blue Shield Association.

Group Employee Application
(For Self-funded and 101+ Markets)

Wellmark Blue Cross and Blue Shield of South Dakota
Fax (515) 376-9101

☐ Late Enrollee ☐ Special Enrollee ☐ Change ☐ Open Enrollment Period ☐ Newly Eligible

A. Employer Information (Completed by Employer)

Group/Billing Unit No. XD003-0011 Department Number _____

Employer Name Black Hills Special Services Cooperative Phone Number (605) 347-4467

Employer Address Line 1 (Street Address or Suite#) PO Box 218, 2885 Dickson Drive

Employer Address Line 2 (PO Box, Street Address) _____

City Sturgis State SD ZIP 57785

B. Employee Information

Name (First, MI, Last) _____

Address Line 1 (Street Address or Apt/Suite#) _____

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

Home Phone Number (_____) _____ Work Phone Number (_____) _____ Ext. _____

Email Address (optional) _____

Date of Birth _____/_____/_____ (mm/dd/yyyy) **Gender:** ☐ Male ☐ Female **Status:** ☐ Single ☐ Married ☐ Domestic partner

Social Security Number/Tax Identification Number _____

(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided. Further review may be necessary if an SSN or TIN is not provided.)

Date of Hire (required) _____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal

Employee Classification _____

Health: ☐ Employee ☐ Employee/spouse or domestic partner
☐ Employee/child(ren) ☐ Employee/spouse or domestic partner/child(ren)

Health Plan Code: _____ **Deductible Amount:** _____

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

☐ Birth
☐ Marriage/domestic partner
☐ Divorce
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Open Enrollment
☐ Other _____
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to South Dakota
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number / Tax Identification Number

D. Members/enrollees Covered If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

List Name (First, MI, Last) of all others to be covered		Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]
☐ Spouse or Domestic Partner		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ______ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a $50 penalty, per violation, assessed to you by the IRS.

[2]If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage (Required)

☐ Yes ☐ No Are you and/or anyone listed in Section D Social Security disabled?

If yes, list names______________________________

☐ Yes ☐ No Are you and/or anyone listed in Section D enrolled in Medicare?

If yes, complete as appropriate:

Employee Name (as it appears on Medicare card) ______________________ Medicare ID ______________________

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Employee Name (First, Last)	Social Security Number / Tax Identification Number

E. Medicare Coverage (Required), cont'd

Spouse or Domestic Partner Name (as it appears on Medicare card) _____ Medicare ID _____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Dependent Name (as it appears on Medicare card) _____ Medicare ID _____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

F. Other Carrier Information (Required)

☐ Yes ☐ No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First, Last)_____ Date of Birth_____/_____/_____

Please list those covered by the other health plan(s)_____

Policy No. Effective Date_____/_____/_____

Employer Name (if coverage is through employer group)_____

Insurance Company/HMO Name_____

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Phone Number (_____)_____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

☐ Yes ☐ No If yes, please complete the following:

List dependent(s)_____

List name of person required to provide health insurance_____

List name of person who has primary physical custody_____

G. Waiver of Enrollment (Please complete if you are waiving health benefits.)

☐ I waive health coverage for my dependents and myself. Please indicate one of the following reasons:

- ☐ I (We) have coverage under another health care benefit plan.
- ☐ I (We) do not wish to enroll in the health plan.

Please see the Important Information Regarding Waiver of Enrollment in Section H of this application.

H. Important Information Regarding Waiver Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within a period of time specified by your employer after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the time specified by your employer after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

I. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota, Inc. (referenced herein as "Wellmark"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to Wellmark on my behalf. This authorization is to remain in effect until Wellmark is notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Wellmark will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

Wellmark requires social security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If social security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the social security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

HSA Coverage

If the High Deductible Health Plan that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Release of Medical Information

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark all health and mental health records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that Wellmark or provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ **Date** _____/_____/_____

Benefits Enrollment Form

Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) 2) Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. 3) For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. 4) Please sign and date the form. 5) Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)		**Employee ID/Social Security Number**	**Date of Birth** (MM/DD/YYYY)
Gender ☐ M ☐ F	**Married** ☐ Yes ☐ No	**Email Address**	
Street Address		**City**	**State** / **Zip Code**
Date of Hire (MM/DD/YYYY)	Hours Worked/Week	Position/Job Title/Physician Specialty	Salary/Earnings
Employer Name Black Hills Special Services Cooperative	Group Policy Number	Class	Location / Division/Department

Covered Life Insurance Dependents (18 or younger) and Spouse Information

Name (First, Middle, Last)	Birthdate	Soc. Sec. No.	Gender
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

For residents of New York (not applicable to Life Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: XXX XX ____
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

THE HARTFORD

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

E

DELTA DENTAL

Enrollment/Change Form

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
(605)224-7345 Fax (605)224-0909
(800)627-3961
www.deltadentalsd.com

Effective Date: _____

Hire Date: _____

Group Name: Black Hills Special Services Coop **Group Number:** 2181

Employee Name: _____ **SSN:** _____

Employee Address: _____ **DOB:** _____

City/State/Zip: _____ **Sex:** ____M ____F

Phone Number: _____ **Email Address:** _____

Marital Status (common law marriage is not recognized in South Dakota): Single ____ Married ____

***List only names of dependents you are enrolling:**

	First	Last (if different)	Sex	Birth Date
☐ Add ☐ Drop	SPOUSE			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			
☐ Add ☐ Drop	CHILD			

Please use additional sheet if you have more dependents.

CHANGE in Coverage (Please list dependents you want removed from your plan in space provided above):

Marriage Date: _____ Divorce Date: _____

Other (explain): _____ Date of Change: _____

****Signature:** _____ **Date:** _____

*I understand that should I decide to apply for single coverage, even though I am eligible for family coverage, I cannot change my policy until open enrollment or a qualifying event (within the past 30 days). I also understand that Delta Dental of South Dakota reserves the right to reject a change form.

**I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period, a qualifying event, or until the termination of my employment.

8/11

kerri.baus@deltadentalsd.com

blank

www.HealthEquity.com

ENROLLMENT FORM
Employee Reimbursement Account and Pre-Tax Premium Payment

Account Owner's Name and Address

Last Name	First Name	M.I	Social Security Number
Street Address		Phone No.	
City		State	Zip
Black Hills Special Services Cooperative	Email Address		Date of Birth (MM/DD/YYYY)

Contribution

- ☐ I do not wish to contribute.
- ☐ I wish to contribute $_____ to my HSA account each pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.
- ☐ I wish to make a single contribution of $_____ to my HSA account on a pre-tax basis. I understand this will be deducted from my paycheck one time only for the tax year _____ .

Important

The annual maximum is the applicable statutory maximum for my High Deductible Health Plan (HDHP) coverage type (i.e., single or family). The IRS may adjust this amount each year. Contributions are prorated based on the number of months I am covered under an HDHP. An exception to this rule allows participants with an HSA who are covered on December 1 to contribute the entire amount for the year. My HSA contribution election can be changed prospectively, for any reason.

By electing HSA benefits, I am certifying that I meet the requirements under Internal Revenue Code § 223 to be eligible to contribute to an HSA. I understand that:

- I must be covered by an HDHP to contribute to an HSA.
- I may not be claimed as a dependent on another individual's income tax return.
- I may not be covered by other medical coverage, including Medicare or my spouse's traditional medical Flexible Spending Account.
- HSA benefits cannot be elected in addition to medical spending account reimbursements unless the Limited Purpose option is selected.

For more information about HSA eligibility requirements, see IRS Publication 969.

Signature

It is my responsibility to determine (1) whether I am eligible to make contributions to my HSA, and (2) whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

_____ _____

Account Owner Date

Pre-Tax Election Form

AFLAC administers BHSSC's tax deferred plan for dental and health insurance premiums. The attached form allows you to elect to have your health and dental premiums deducted on a pretax basis. Completing this form is required however it does not enroll you in AFLAC. For information on AFLAC, contact Susan Soehren at 341-4701 or susan_soehren@us.aflac.com.

Employee Name: _____

Mailing Address: _____

Work Site: _____

Start Date: _____

Supervisor: _____

The information above and the attached form will be released to AFLAC.

AFLAC Fax Number: 341-4777

blank

SALARY REDIRECTION AGREEMENT

EMPLOYER: _____

EMPLOYER TAX ID NUMBER: ___ ___ -- ___ ___ ___ ___ ___ ___ ___

AFFILIATE NAME/LOCATION: _____

AFFILIATE TAX ID NUMBER: ___ ___ -- ___ ___ ___ ___ ___ ___ ___

Flex One® FSA? ☐ Yes ☐ No CAFETERIA PLAN YEAR: ___/___/___ -- ___/___/___

(CHECK ONE) ☐ OPEN ENROLLMENT OR ☐ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___/___/___

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___) _____

NAME: (Last) _____ (First) _____ (Middle Initial) ___

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: _____ Date of first deduction: ___/___/___ Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to "employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage			Accident Insurance		
Dental Insurance			Short-Term Disability Insurance		
Vision Care Insurance			Long-Term Disability Insurance		
Cancer Insurance			Hospital Indemnity Insurance		
Intensive Care Insurance			Personal Sickness Indemnity		
Specified Health Event			Health Savings Account (HSA) §223		
Group Term Life Insurance (If family, must be after-tax)			Other accident or health plan(s) under section 106 of the Internal Revenue Code List: _____		

Complete the following section *only* if participating in a Medical or Dependent Care Reimbursement Plan:

Medical Care FSA Plan: ($ _____ per pay period) X (_____ number of deductions) = $ _____ Annual Election

Dependent Care FSA Plan: ($ _____ per pay period) X (_____ number of deductions) = $ _____ Annual Election

Required acknowledgement to participate in Flexible Benefits Plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan. INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan. INITIAL

EMPLOYEE SIGNATURE: _____ **DATE:** _____

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE FLEXIBLE BENEFITS PLAN

I understand and agree to the following:

- **Restrictions on Election Changes:** On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in status" occurs (as defined under the Plan and the Internal Revenue Code), and the change is caused by and consistent with the "change in status." I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.

- **Commencement of Coverage and Status of Prior Elections:** Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Department Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

- **Use of Personal Information:** In addition to and without limiting in any way the rights my employer, the Plan, their service provider (Aflac and Flex One®) and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider (Aflac and Flex One) and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

- **Effect of Pre-Tax Contributions on Benefit Payments:** Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.

- **FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANT:** I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse my employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by my employer and such amounts may (but are not required to) be used to offset administrative expenses or future costs, and that the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by my employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount. I acknowledge that in some cases reimbursement for eligible Medical and Dependent Care FSA expenses may be administered through an electronic payment card ("the Card") and agree to abide by the terms and conditions of the Plan with regard to such card usage and the electronic payment cardholder agreement, including any fees applicable to the Card, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. I also agree to use the Card exclusively for Medical and/or Dependent Care FSA expenses and to retain paper documentation for any claims adjudicated by the Card.