SCHOOL DISTRICT OF PHILADELPHIA

Member Application and Change Form
Phone: (215) 400-4630 Fax: (215) 400-4631 Email: Benefits@philasd.org

Instructions: This application allows you to enroll in a School District of Philadelphia (SDP) insurance plan(s), or to make certain changes if you are already a member. Carefully fill out the form and print clearly.

❶ Employee Information

First Name	
Last Name	
Social Security Number	___ ___ ___ - ___ ___ - ___ ___ ___ ___
Daytime Phone Number	

❷ Reason for Application

Application Type: *Select **One***

- ☐ New Hire/Rehire
- ☐ Open Enrollment:
  Requests must be received between May 1 and May 31. Changes are effective July 1.
- ☐ Qualifying Life Event:
  Requests must be received within thirty (30) days of the life event date along with appropriate documentation. We reserve the right to adjust bi-weekly premiums due to Life Event change in enrollment status

Request Type: *Select all that apply*

- ☐ Elect Coverage
- ☐ Terminate Coverage
- ☐ Add spouse/dependent(s)
- ☐ Remove spouse/dependent(s)
- ☐ Change Plan Type
- ☐ Other: _____

❸ Select a Plan Type

Medical Plans: *Select **One***

- ☐ HMO-Keystone Health Plan East
- ☐ PPO-Personal Choice
- ☐ PPO-Modified Personal Choice 320
- ☐ **Waive** Medical Insurance

Ancillary Plans: *Select all that apply*

Non-Represented, CASA & SPAP only

- ☐ Dental- United Concordia
- ☐ Vision & Prescription- IBC
- ☐ **Waive** Ancillary Insurance

❹ Covered Family Member Information

Complete all information for each person to be covered. You must provide documentation for each dependent. See back of application for a description of the required documents.

		First Name	MI	Last Name
SPOUSE* ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental			
		Social Security Number	**Gender**	**Date of Birth**
			M F	

* **CASA, PFT & Non-Represented** employees must complete the *Letter of Attestation*. See back side of the application for the *Letter of Attestation.*

		First Name	MI	Last Name
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental			
		Social Security Number	**Gender**	**Date of Birth**
			M F	
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental	**First Name**	**MI**	**Last Name**
		Social Security Number	**Gender**	**Date of Birth**
			M F	
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental	**First Name**	**MI**	**Last Name**
		Social Security Number	**Gender**	**Date of Birth**
			M F	

❺ Signature and Verification- Read carefully and sign

Your application CANNOT be processed without your signature. 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 subjects such person to employment, criminal and civil penalties.

_____ _____
Employee Signature **Date**

INTEROFFICE USE ONLY	EFFECTIVE DATE OF COVERAGE	DOCUMENTS/NOTES

Letter of Attestation

School District of Philadelphia Spousal Benefits Eligibility

Employees represented by **CASA, PFT** or are **NON-REPRESENTED** must carefully read and complete this section if enrolling a spouse or same sex life partner. SDP reserves the right to audit the below information at any time.

Employee Name (PRINT): _____

Last Four Digits of SSN: _____

Employee Type (Select One ☑): ☐PFT ☐Non-Represented ☐CASA ☐SPAP

I hereby attest that I am legally married to my spouse or am in a same-sex life partnership registered with the City of Philadelphia Commission on Human Relations or other locality or

state with, _____, and that my spouse or life
Spouse's or Life Partner's Name

partner is :

☐**not eligible** for group health insurance coverage offered by his or her employer that (a) qualifies as minimum essential coverage,[1] (b) is adequate,[1] within the meaning of the Patient Protection and Affordable Care Act. Therefore**, I am not subject** to the spousal/life partner surcharge imposed by the School District of Philadelphia.

☐**eligible** for group health insurance coverage offered by his or her employer that (a) qualifies as minimum essential coverage,[1] (b) is adequate within the meaning of the Patient Protection and Affordable Care Act. Therefore, **I am subject** to the spousal/life partner surcharge by the School District of Philadelphia.

☐ **is a School District of Philadelphia employee**. Therefore, **I am not subject** to the spousal/life partner surcharge imposed by the School District of Philadelphia.

I acknowledge that should my spouse's or life partner's eligibility for coverage, or the nature, adequacy or affordability of my spouse's or life partner's coverage change, it is my responsibility to notify the School District of Philadelphia Employee Benefits Office *within 30 days of the change*. I declare that the above statement is true, complete and correct to the best of my knowledge. I understand that if my attestation set forth above is not true, complete and correct, I may be subject to disciplinary action, up to and including termination of my employment with the School District of Philadelphia.

_____ _____/_____/_____

Signature **Date**

[1] "Minimum essential coverage" includes (1) coverage under specified government programs; (2) health insurance coverage obtained in the individual market that provides for essential health benefits; (3) health insurance coverage obtained in the small group market that provides for essential health benefits; (4) health insurance coverage obtained in the large group market; (5) employer-sponsored group health plans (whether insured or self-funded); (6) grandfathered health plan coverage, whether or not it is provided through health insurance coverage; and (7) other coverage such as self-funded student health coverage, foreign health coverage, refugee medical assistance, Medicare advantage plans, State high-risk pool coverage, and AmeriCorp volunteer coverage.

[1] "Adequate" means the plan pays for at least 60% of medical expenses on average.

Eligibility Chart

Refer to the chart below for which plan(s) you may be eligible. Each plan may be subject to a **biweekly premium**. See website for current rates.

Plan Type	PFT	CASA	NON - REPRESENTED	LOCAL 634	SPAP
HMO- Keystone Health Plan East	Yes	***NO***	***NO***	Yes	Yes
PPO- Personal Choice	Yes*	Yes	Yes	***NO***	Yes*
PPO- Modified Personal Choice 320	***NO***	Yes	Yes	***NO***	***NO***

** A four-year waiting period applies, per collective bargaining agreements and District policies.*

Required Documentation

If you wish to cover a spouse and/or a dependent on any of the insurance plans (medical or ancillary) with the District, you must provide documentation.

To cover a:	You must provide:
Spouse	Certified Marriage Certificate AND **ONE** of the following • Current mortgage statement, home equity loan, or lease agreement • Current Property Tax documents • Automobile registration that is currently in effect • Current credit card or account statement • Current utility bill • Current designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under an employee's will • Assignment of a durable property power of attorney or health care POA • Valid government-issued ID • Page 1 and signature page or Page 1 and certificate of filing/email confirmation of electronic submission of employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the spouse
Same Gender Domestic Partner	Commission on Human Relations letter from the City of Philadelphia or comparable official document AND **ONE** of the documents listed in the "SPOUSE" section.
Child under the age of 26	***NEWBORNS***: Within 30 days of birth, hospital record with child's information. Within 60 days of birth, Birth Certificate and Social Security Number. **All other children**: Birth Certificate and social security number. Proof of dependency may be required such as adoption paperwork.
Disabled child, age 26 or older	Birth Certificate, social security number and Certification as an individual with a disability.
Step-child, under the age of 26	Marriage certificate indicating step-child's biological parent is married to the employee, birth certificate listing spouse as parent and divorce decree indicating spouse is primary care giver or signed statement from attesting to financial responsibility from biological parent.

**"Current" is defined as within the last 12 months.*