LifeMap Assurance Company
100 SW Market Street
PO Box 1271 E-8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

Group Vision Insurance Employee Enrollment and Change Form

Please complete all information on this page and on page 2.

Employer Name **Highland School District**	**Group Number**

☐ New Group ☐ Open Enrollment ☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____

☐ Change of Existing Enrollment ☐ COBRA ☐ Cancelation

For any change to existing enrollment, cancelation, or continuation of coverage, please indicate reason below.

Employee's Name (Last, First, MI)		☐ M ☐ F	Date of Birth
Social Security Number	☐ Married or Domestic Partner ☐ Divorced ☐ Single		Telephone Number ( )
Home Address & Apt. No./Mailing Address	City		State Zip

Dependents to be enrolled: Dependent children must be under 26 years of age.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship to You	Enroll for coverage
			☐ M ☐ F		☐ Vision
			☐ M ☐ F		☐ Vision
			☐ M ☐ F		☐ Vision
			☐ M ☐ F		☐ Vision

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If changing existing enrollment, indicate reason below:

☐ **Name Change** – Former name _____ ☐ Address Change

Add Dependent(s)

Add Dependent(s) due to ☐ Open Enrollment ☐ Marriage or Domestic Partnership – Date _____

☐ Newborn - Date of Birth _____ ☐ Adoption - Date of Placement in Home _____

☐ Loss of Coverage - Date _____ Reason _____

Name of Prior Carrier _____ Telephone Number _____

Prior Policy Number _____ Identification Number _____

Coverage was ☐ Group ☐ Individual ☐ Medical ☐ Vision

Coverage was for ☐ Self ☐ Spouse or Domestic Partner ☐ Child(ren) ☐ Family as listed above (check all that apply)

Please complete page 2 before signing and submitting your Enrollment or Change Form

Cancelation of Coverage

Delete Dependent(s) due to: ☐ Dependent no longer eligible – Date dependent was no longer eligible _____

☐ Death - Date _____ ☐ Divorce/Term. of Dom. Part. - Date _____

Delete ☐ All Dependents ☐ Dependent(s) Name(s) _____

Continuation of Coverage

Termination of Coverage was due to: ☐ Termination of Employment ☐ Reduction in hours ☐ Military Leave

☐ Employee's Death ☐ Other _____ Date of Qualifying Event _____

Other Coverage Information This is not a waiver of coverage. This information is required for payment of claims.

Vision coverage? ☐ Yes ☐ No

If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage				Relationship
Name of Insurance Carrier				Carrier Phone Number ( )
Address of Other Carrier	City	State	Zip	Effective Date of Coverage
Policy Number _____	ID Number _____			Termination Date (if applicable)
This plan covers (check all that apply) ☐ Self ☐ Spouse or Domestic Partner ☐ Child(ren) ☐ Family as listed above				
Is the coverage of any dependent affected by a divorce decree/court order? ☐ Yes ☐ No If yes, please include portion of decree that shows responsibility for health expenses.				

I hereby apply for enrollment with LifeMap Assurance Company under the Group Vision Insurance Policy of the Employer named on Page 1. I hereby authorize the Employer named on Page 1 to withhold insurance premiums, if required, from my paycheck and to pay them directly to LifeMap Assurance Company.

I acknowledge and understand LifeMap Assurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, ophthalmologist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, or hospital records (including nursing records and progress notes).

I may cancel this authorization at any time by sending a written request to LifeMap. Cancellation of this authorization will not affect any action LifeMap took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first.

Note: The Group Vision Care Insurance Policy provides vision benefits only. Review your policy carefully.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date. I acknowledge that I have read the Fraud Notices attached to this form.

▶ _____ ▶ _____ ▶ _____

Employee's Full Name (please print clearly) Employee's Signature Date