



LifeMap Assurance Company™  
 100 SW Market Street  
 P.O. Box 1271 E-3A  
 Portland, OR 97207-1271  
 (503) 721-7161 • (800) 794-5390

## Group Vision Care Insurance Employee Enrollment and Change Form

**For residents of Washington**, the definition of a Spouse includes your legal husband or wife or your State Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

**For residents of Idaho**, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

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

<b>Employer Name</b> Cassia County School District		<b>Group Number</b> ID039021	
<input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____ <input type="checkbox"/> Change of Existing Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Non-COBRA Continuation of Coverage <input type="checkbox"/> Cancellation <b>For any change to existing enrollment, cancelation, or continuation of coverage, please indicate reason below.</b>			
Employee's Name (Last, First, MI)		<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Social Security Number	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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 (Spouse, Child)
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

**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:**

<input type="checkbox"/> Name Change – Former name _____	<input type="checkbox"/> Address Change
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### Add Dependent(s)

<input type="checkbox"/> Add Dependent(s) due to: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage / Domestic Partnership – Date _____
<input type="checkbox"/> Newborn - Date of Birth _____ <input type="checkbox"/> Adoption - Date of Placement in Home _____
<input type="checkbox"/> Loss of Coverage - Date _____    Reason _____
Name of Prior Carrier _____    Telephone Number _____
Prior Policy Number _____    Identification Number _____
Coverage was <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medical <input type="checkbox"/> Vision
Coverage was for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> 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.

**Do you or any family members enrolling have other 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) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family as listed above				
Is the coverage of any dependent affected by a divorce decree/court order? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Care 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, optometrist, 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).

**Insurance Fraud Warning:**

**Unless specific state language is provided below**, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

**For residents of 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 include imprisonment, fines, and denial of insurance benefits.

**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.

▶ \_\_\_\_\_ ▶ \_\_\_\_\_  
Employee's Full Name (please print clearly) Employee's Signature

▶ \_\_\_\_\_  
Date Signed