2015-2016 OPEN ENROLLMENT COMMUNICATIONS

It is hard to believe that summer is almost here. Now that Spring is well on its way it means now is the time to being open enrollment for the 2015-2016 Fiscal Year.

As always we are committed to offering a benefits package that provides options for both you and your family’s health, wellness and financial security. We have worked diligently to design a program that furnishes you and your family with access to quality health and wellness programs and provides protection against a possible catastrophe. We are pleased to announce the 2015-2016 benefits program for the Hamilton Wenham Regional School District (HWRSD).

As in past years, healthcare costs continue to rise and are expected to continue increasing. These increases can be attributed primarily to the Affordable Care Act (ACA) and a higher utilization of services due to the aging baby boomer generation. That being said, thanks to the hard work and dedication of District Leadership it is with great pleasure that we announce we will continue providing Harvard Pilgrim plans with a (4) percent decrease in our premiums for the next year. In addition the District will continue to contribute 60% of the plan costs while maintaining the HRA reimbursement agreement, for eligible employees.

We want to encourage you to continue to be an advocate of your health. Our lifestyle choices have the greatest correlation to our well-being. When we shop for healthy foods and seek out ways to increase our physical activity, we reduce our risks for a number of diseases including diabetes and heart disease. Your enthusiasm and feedback motivate us to deliver a benefit design that helps you meet your personal health goals.

The 2015-2016 Open Enrollment for group health and voluntary insurance will take place from May 8, 2015 through June 5, 2015 for changes effective July 1, 2015. Open enrollment is your opportunity to review your benefits coverage and make choices for the upcoming plan year. Therefore, it is important that you read and understand all of the offerings. The Commonwealth of Massachusetts requires enrollment in a health plan. If you are waiving the District offered healthcare coverage for this plan year you MUST complete the Health Insurance waiver, located on page 11 and return it to Human Resources. If you have questions contact Human Resources at (978) 626-0915. Remember employee benefit options vary depending on eligibility.
HOW TO ENROLL OR MAKE CHANGES

**Harvard Pilgrim HealthCare**

A passive enrollment will occur for medical insurance during this open enrollment period. This means that for those employees who do not wish to make any changes to their current elections your enrollment information will roll over to the 2015-2016 plan year automatically. For employees wishing to enroll or make changes to their current medical coverage, an enrollment form **MUST** be completed. If you are currently enrolled and are electing not to continue coverage for the new plan year, you **MUST** complete the enrollment form as well and elect voluntary cancellation under the termination section or your benefits will continue into the new plan year under passive enrollment. **These forms should be completed, signed and returned to Human Resources, no later than Friday, 1:00 p.m. on June 5th.**

**Dental Insurance**: Due to a significant increase in the premium cost (33%) for the existing voluntary Delta Dental plan offered through the District, the District has decided to transition to Dental Blue’s voluntary dental plan Effective July 1, 2015. Blue Cross Blue Shield has a strong dental provider network, therefore there should be no disruption in services. Open enrollment for this product will be passive, unless you are a new member or a member making a change in which case you **MUST** actively enroll in this plan. To enroll, you must complete and submit an enrollment form to Human Resources, Attn: Open Enrollment, no later than Friday, June 5, 2015 at 1:00 p.m.

**Aflac**

Open enrollment for AFLAC products will be active with an effective date of 10/1/15. To inquire about a specific benefit and/or its cost contact Richard Wilson, Aflac Agent via email at r1_wilson@us.aflac.com or by phone at (617)378-7432. See page 6 for more details on Aflac’s Supplemental plans.

**Sprint**

HWRSD employees who utilize Sprint as their mobile carrier are eligible to receive up to an 18% discount off of their shared data monthly charge. To verify eligibility go to [https://mysprint.sprint.com/verify/](https://mysprint.sprint.com/verify/). If you’re not a Sprint member, but would like to consider porting your existing lines from another carrier over to Sprint go to [https://sprint.com/joinsprint/](https://sprint.com/joinsprint/) to view Sprints’ current offers.
Benefit Plan Overview

In general, eligible employees regularly scheduled 20 or more hours per week may participate in the group medical and dental benefits offered by the District.

**MEDICAL INSURANCE**

For the plan year beginning July 1, 2015, we are pleased to announce that group medical benefits will continue to be offered through Harvard Pilgrim Health Care, and the plan offerings will remain the same.

There will be 4.0% decrease in our premiums as compared to the current year. The District will continue to pay 60% of the premiums for the 2015-2016 Fiscal Year.

The chart below provides a brief overview of HPHC plan offerings.

<table>
<thead>
<tr>
<th>Current Plan Benefits</th>
<th>HPHC HMO</th>
<th>HPHC PPO</th>
<th>HPHC POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit / Well Care</td>
<td>Covered In Full</td>
<td>Covered In Full</td>
<td>Covered In Full</td>
</tr>
<tr>
<td>Physician Office Visit / Medical Care</td>
<td>$20 Copay per visit</td>
<td>$20 Copay In-net &amp; deductible/co-ins OON</td>
<td>$20 Copay In-net &amp; deductible/co-ins OON</td>
</tr>
<tr>
<td>Deductible</td>
<td>$500 individual / $1,000 family*</td>
<td>$250 / $500 out-of-Network Only</td>
<td>$250 / $500 out-of-Network Only</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum: Members cost sharing features</td>
<td>$2,000 individual / $4,000 family (except Rx co-pays)</td>
<td>$1,000 / $2,000 In-Network &amp; $1,000/$2,000 Out-of-Network</td>
<td>$1,000 / $2,000 In-Network &amp; $1,000/$2,000 Out-of-Network</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>20% Out-of-Network Only</td>
<td>20% Out-of-Network Only</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 Copayment After Deductible (Waived if admitted)</td>
<td>$100 Copayment (Waived if admitted)</td>
<td>$100 Copayment (Waived if admitted)</td>
</tr>
<tr>
<td>IN-PT Hospital Admission</td>
<td>Covered In Full After Deductible</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
</tr>
<tr>
<td>OUT-PT Surgical Day Care Ambulatory Surgical Facility</td>
<td>Covered In Full After Deductible</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
</tr>
<tr>
<td>Lab &amp; X-rays</td>
<td>Covered In Full After Deductible</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
</tr>
<tr>
<td>CAT Scans, MRI, PET Scans</td>
<td>Covered In Full After Deductible</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
<td>Covered In Full In Net &amp; deductible/co-ins OON</td>
</tr>
<tr>
<td>RX - 30 Day Retail or 90 Day Mail Order Delivery</td>
<td>$15 / $25 / $40</td>
<td>$15 / $25 / $40</td>
<td>$15 / $25 / $40</td>
</tr>
</tbody>
</table>

**EE Monthly Contribution 07/01/2015**

<table>
<thead>
<tr>
<th></th>
<th>Single $263.99</th>
<th>Family $707.50</th>
<th>Single $412.13</th>
<th>Family $1,104.51</th>
<th>Single $ 343.76</th>
<th>Family $921.27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Monthly Rates 07/01/2015</td>
<td>$659.98</td>
<td>$1,768.75</td>
<td>$1,030.32</td>
<td>$2,761.28</td>
<td>$859.39</td>
<td>$2,303.18</td>
</tr>
</tbody>
</table>

**Employee contributions are deducted from each payroll, based on the employees pay cycle and on a pre-tax basis.**
REMINDERS

1. Governmental regulations require that all employees carry medical insurance. Therefore, any employee who declines participation in HWRSD’s group medical insurance plan each plan year MUST complete a waiver electing not to enroll in the plan(s) offered by HWRSD. Anyone who is not electing coverage MUST complete and submit the waiver form to Human Resources by the end of the open enrollment process even if you have done so in prior years.

2. Qualified events allow you to make changes to your benefits during the plan year rather than waiting for the next open enrollment. If you experience a special enrollment circumstance or change in family status such as birth of a child, marriage or divorce please contact Human Resources to discuss possible options.

3. Once you choose a specific health plan (e.g. HMO, PPO, POS) you cannot change to another plan until the next open enrollment period without a qualifying event. A loss or change of provider is not considered a qualifying event.

4. If your physician is no longer an eligible provider for the plan you have chosen, you must choose a new participating provider and update it with Harvard Pilgrim.

5. Eligible dependent(s) include your spouse and your child(ren) up to their 26th birthday (or a child of any age who became disabled prior to age 26). This includes natural children, step children, adopted children, and children for whom you are a court appointed guardian. It also includes any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

6. You do not need to provide eligibility documentation (e.g., a marriage or birth certificate) for currently covered dependents. However, documentation is required for new enrollees or to add a dependent.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Health Care Reimbursement Account (HRA) for the qualified HMO plan will continue unchanged for the next year. This reimbursement account assists eligible employees with payment of deductible related expenses.

The administrator of the HRA account is HR Concepts. HR Concepts facilitates the reimbursement of eligible deductible related expense for participants in the HMO plan with funds set aside by the District. For further information on how HR Concept’s Health Reimbursement Account works check out their website at http://www.hrconcepts.biz.php5-2.dfw1-1.websitetestlink.com/Services/hra.html
# DENTAL BLUE VOLUNTARY DENTAL INSURANCE

## Hamilton Wenham Regional School District

### FY2015-2016 Supplemental Dental Blue Plan

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>BCBS Dental Program 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$50 / $150 waived for Preventive</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,250</td>
</tr>
<tr>
<td>Out-of-Network Reimbursement</td>
<td>90th Percentile UCR</td>
</tr>
<tr>
<td>Diagnostic Services - Preventive</td>
<td>100% In/Out of Network</td>
</tr>
<tr>
<td>Restorative, Oral Surgery, Periodontics, Endodontics &amp; Prosthetic Maintenance</td>
<td>80% In/Out of Network</td>
</tr>
<tr>
<td>Major Restorative, Prosthodontics</td>
<td>50% In/Out of Network</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>50% up to $1,000 Lifetime Max</td>
</tr>
<tr>
<td>Rollover Maximum Accumulation</td>
<td>Yes</td>
</tr>
<tr>
<td>Required Employer Contribution</td>
<td>NA</td>
</tr>
<tr>
<td>Required Minimum Participation</td>
<td>25%</td>
</tr>
<tr>
<td>Vision Benefits</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY2015-2016 Monthly 3 tier Rates</th>
<th>Single $39.97</th>
<th>Plus 1 $83.09</th>
<th>Family $143.50</th>
</tr>
</thead>
</table>

*Note: Enhanced Dental Benefits for CAD and Diabetes*

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**DEARBORN NATIONAL:** Enrollment forms for this plan are held in Human Resources, for further information contact [d.oneil@HWSchools.net](mailto:d.oneil@HWSchools.net) or (978) 626-0915.
AFLAC

Help protect yourself and your family from out-of-pocket costs in the event of a covered sickness or injury with the cash to help cover bills by purchasing one of AFLAC’s supplemental plans. Aflac policies are 100% employee paid and are available on a voluntary basis. They are offered to assist employees with rising costs of out-of-pocket health care expenses. Aflac offers a wide variety of policies, such as:

**Short Term Disability:** If you become sick or injured and can’t work, your paychecks will stop but your bills won’t. AFLAC Disability replaces your lost income, and benefits are paid regardless of any other insurance coverage. Customized for each person to fit your income and budget needs, and MATERNITY leave is included.

**The Cancer Plan:** Cancer can be financially devastating and a life altering event. Expenses skyrocket, and if a family member also has to stop working to care for a loved one, the loss of income maybe doubled. AFLAC helps provide an important safety net in fighting the financial consequences of critical illness, and has saved countless families from bankruptcy by providing a lump-sum benefits payment.

**Accident Insurance:** If an accident occurs up to 50% of the costs come out of your pocket in the form of co-pays, deductibles, travel, parking, medications, etc. AFLAC pays cash directly to you for accidents, on or off the job, and how you choose to use that money is up to you. Family coverage is available and great if you have young active kids.

**Hospital Indemnity:** Hospital Indemnity pays cash to you to help with deductibles, co-pays, and prescriptions, as well as to provide help for loss of income, rent, etc. Family coverage is available and pays for hospital confinement as it relates to an accident or illness; or a visit to your physician due to illness or injury. Short stay benefits are included, as well as anesthesia and surgical benefits. Well baby visits are an added bonus to the plan along with many other features not listed.

**Dental Insurance:** You can flash a great smile with AFLAC Dental Insurance. There is NO NETWORK, so you have the freedom to choose your own dentist, and AFLAC pays benefits regardless of any other dental plan you may have. AFLAC is offering a Basic dental plan to provide you with extra coverage on top of your existing coverage. As well as the standard plan $1400 coverage per person per year, coverage goes up $100 per year for 5 years at end of 5 years your protection is $1900 of coverage per person with no premium increase.
FLEXIBLE SPENDING PLAN (FSA):

With rising healthcare costs, every penny counts. An FSA Plan allows employees to set aside pre-tax dollars to pay for qualified healthcare expenses. Such as co-pays, prescriptions, deductible related expenses, dental, orthodontia and vision care. HWRSD’s FSA Plan is administered by TASC with an open enrollment period beginning in September.

In addition to being able to set aside pre-tax dollars to pay for qualified healthcare expenses an employee can set aside funds for eligible dependent care expenses incurred during the plan year as well.

If you believe you may be interested in participating in the FSA plan and would like further information please go to https://www.tasconline.com/products/flexsystem/ and click on the link FlexSystem Participant Presentation.

Further information regarding enrollment for the FSA will follow as the plan year draws near.

403(B) RETIREMENT PLAN

Employees from private companies may turn to 401(k) plans to help build their retirement savings. However, if you’re a school teacher or work for a tax-exempt organization, a 403(b) retirement plan may help provide additional support to reach your retirement goals. Tax-deferred 403(b) plans are designed for employees of public schools, colleges and universities, and churches. Employees of certain tax-exempt, non-profit organizations, such as charities and some hospitals, also may participate in a 403(b) retirement plan – which is also known as a tax-sheltered annuity or tax-deferred annuity.

A 403(b) retirement plan lets you put a portion of your salary into an employer-sponsored plan to help you save for retirement. You don’t pay taxes on what you contribute or any earnings you may accumulate until you withdraw the money – ideally, when you’re retired and you may be in a lower tax bracket.

Enrollment in HWRSD’s 403(b) retirement plan is offered year round with deductions beginning the payroll following enrollment. If you are interested in enrolling or have questions please reach out to HR for assistance at (978)-626-0915 or via email at d.oneil@HWSchools.com.

EMPLOYEE ASSISTANCE PROGRAM

The HWRSD Employee Assistance Program is available to employees and their families 24 hours a day, 7 days a week by calling 1-800-451-1834. This free CONFIDENTIAL counselling and referral service offers:

1. Three (3) confidential in-person or phone counseling sessions to:
   • Manage Anxiety/Depression/Addiction/ Adjust to Demands of Work/Stress level assessment
   • Resolve Relation Conflict/Become a Better Communicator/Address Parenting and Family Issues
2. One free 30 minute office or telephone consultation per legal matter (does not include job related issues) and one free 30 minute office or telephone consultation per financial issue.
   • Divorce or Child Custody
   • Real Estate/Landlord/Tenant Issues/Car Accidents
   • Financial Planning/Tax Advice/Credit Card Debt/College Planning/Retirement Consultation

For further information on the EAP program or to read any of MIIA’s educational materials and newsletters please go to http://www.allonehealth.com/MIIAEAP/.
INFORMATIONAL MEETING TIMES

Dawn O’Neil, the District’s new HR & Benefits Administrator, will host open enrollment informational meetings at each school during the open enrollment period to answer questions and assist our staff with the completion of enrollment/change forms:

<table>
<thead>
<tr>
<th>School</th>
<th>Date</th>
<th>Location</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutler Elementary</td>
<td>May 19</td>
<td>Lunchroom</td>
<td>11:45am to 12:45pm</td>
</tr>
<tr>
<td>Winthrop Elementary</td>
<td>May 20</td>
<td>Lunchroom</td>
<td>1:00pm to 2:00pm</td>
</tr>
<tr>
<td>Buker Elementary</td>
<td>May 21</td>
<td>Lunchroom</td>
<td>11:00am to 1:00pm</td>
</tr>
<tr>
<td>Middle School and High School</td>
<td>May 22</td>
<td>Library</td>
<td>9:00am to 10:00am</td>
</tr>
<tr>
<td>Winthrop Elementary</td>
<td>May 25</td>
<td>Lunchroom</td>
<td>11:30am to 12:30pm</td>
</tr>
<tr>
<td>Middle School and High School</td>
<td>May 26</td>
<td>Library</td>
<td>10:00am to 11:00am</td>
</tr>
<tr>
<td>Cutler Elementary</td>
<td>May 27</td>
<td>Lunchroom</td>
<td>11:45am to 12:45pm</td>
</tr>
</tbody>
</table>

Informational packages and enrollment forms will be distributed at these meetings, or they can be obtained by contacting Human Resources at (978) 626-0915 or via email at d.oneil@HWSchools.net.
FORMS TO COMPLETE

MEDICAL INSURANCE

Any employee interested in participating (that was not previously enrolled in the plan they wish to elect) and/or any employee who wishes to make changes to their previously elected plan MUST complete a HPHC Enrollment form and elect their chosen plan—HMO, PPO or POS, ensuring that all employee sections are complete including PCP selection if required by the plan selected.

HEALTH COVERAGE WAIVER FORM

Governmental regulations require that all employees carry medical insurance. Therefore, any employee who declines participation in HWRSD’s group medical insurance plan MUST complete a waiver electing not to enroll in the plan(s) offered by HWRSD. Anyone who is not electing coverage MUST complete and submit the waiver form to Human Resources by the end of the open enrollment process even if you have done so in prior years.

HEALTHCARE REIMBURSEMENT

Eligible employees who enroll in the qualified HPHC HMO plan will automatically be enrolled in the HRA.

DENTAL INSURANCE

Any employee interested in participating (that was not previously enrolled in the plan) and/or any employee who wishes to make changes to their previously elected plan MUST complete a Dental Blue Enrollment form,

AFLAC

Any employee electing to enroll in an AFLAC participating plan MUST contact HWRSD’s AFLAC agent to complete an enrollment form. A copy of the enrollment form should be submitted to Human Resources as well as the AFLAC agent for processing.

BENEFICIARY DESIGNATIONS AND PERSONAL INFORMATION

Open enrollment is a good time to review your beneficiary designations for your 403(b) and life insurance plans. You may also want to ensure that your Retirement System has up to date beneficiary designations as well. Additionally, this is a good time to update your personal and emergency contact information.

If you would like to request a Beneficiary Change form or Personal Demographic/Emergency contact Update form please contact Human Resources.

FLEXIBLE SPENDING AND HWRSD’S 403(b)

Enrollment forms for these plans are held in Human Resources, for further information contact d.oneil@HWSchools.net or (978) 626-0915.
# 2015-2016 Annual Open Enrollment

<table>
<thead>
<tr>
<th>TO BE COMPLETED BY HP HC ONLY</th>
<th>GROUP / COMPANY NAME</th>
<th>DATE OF HIRE</th>
<th>GROUP / DIVISION</th>
<th>EFFECTIVE DATE 7/1/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP</td>
<td>Hamilton-Wenham Regional School District</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMPLOYEE NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIRST NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIDDLE NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAST NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME ADDRESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STREET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td></td>
<td>STATE</td>
<td>ZIP</td>
<td>COUNTY</td>
</tr>
<tr>
<td>TELEPHONE (HOME)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TELEPHONE (WORK)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIRST NAME (IF NOT SAME AS EMPLOYEE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIDDLE NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAST NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMPLOYER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPOUSE</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>DEPENDENT</td>
<td></td>
<td></td>
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<tr>
<td>DEPENDENT</td>
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</tr>
<tr>
<td>DEPENDENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LANGUAGE CODES (OPTIONAL)</td>
<td>AS</td>
<td>CA</td>
<td>CV</td>
<td>EN</td>
</tr>
<tr>
<td></td>
<td>American Sign Language</td>
<td>Czeck</td>
<td>Russian</td>
<td>English</td>
</tr>
</tbody>
</table>

1. IF YOU HAVE LISTED A FULL-TIME STUDENT’S NAME, AGE 15 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION:

- NAME
- NAME OF SCHOOL
- STATE

HAVE YOU EVER BEEN A MEMBER OF HP HC, HP HC OR NE, OR HP HC INSURANCE COMPANY? [ ] YES [ ] NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

EMAIL ADDRESS: ____________________________ (OPTIONAL)

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY.

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. FOR AN EXPLANATION OF HOW HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT.

IT IS A CRIME TO KNOWINGLY PROMISE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY Include IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

______________________________  ____________________________
EMPLOYEE SIGNATURE            EMPLOYER SIGNATURE
MA Healthcare Coverage Waiver Form

Employer Company Name: Hamilton-Wenham Regional School District

Employee Name: ________________________________

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

**Waiving Group Health Coverage** *(Please select one of the following)*

- [ ] I am covered under another group plan as a spouse or dependent
- [ ] I am covered by the Mass Health, Medicare, or Veterans Program
- [ ] I am covered under another group plan sponsored by a second employer
- [ ] I am covered through a non-group, individual or private health care plan not offered through my employer
- [ ] I do not wish to participate in health care benefits at this time
  (I am declining health insurance entirely)

*If the reason stated above for waiving coverage is that you have coverage elsewhere, provide the following information:*

Carrier Name: ________________________________

Subscriber Name: ________________________________

---

I affirm that the information I have provided on this form is true and complete to the best of my knowledge and belief. I understand that Harvard Pilgrim may either refuse to renew coverage or terminate coverage, retroactive to the effective date, for any material misinformation (including omissions) contained in this form.

I understand that any person choosing to enroll at a time other than during my employer’s open enrollment must meet Harvard Pilgrim’s requirements for eligibility and the special enrollment rights summarized below.

**EMPLOYEE SIGNATURE: ________________________________   DATE: ________________________________**

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**Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights may also apply if you lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.
1. **To Be Filled Out by Your Employer**

   **Company**
   **Name** HAMILTON WENHAM REGIONAL SCHOOL DISTRICT

   **Requested Effective Date** JULY 01, 2015
   **Date of Hire**

   **Group #**

   **Type of Transaction**
   - [ ] ADD
   - [ ] CHANGE
   - [ ] CANCEL
   - Three digit termination code

   **Remarks:** (i.e., qualifying event for a new add, change to family or other instruction)
   - [ ] Open Enrollment
   - [ ] New Hire
   - [ ] Change to Family
   - [ ] Add Spouse
   - [ ] Add Dependent
   - [ ] Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
   - [ ] Other: ____________________________________________

2. **Yourself (Member 1)**

   **Product?** [ ] Dental Blue

   **Membership Type**
   - (Dental) [ ] Individual
   - [ ] Individual + One
   - [ ] Family

   **Your First Name**
   **M.I.**
   **Last Name**

   **Street Address/PO. Box #**
   **Apt. #**
   **City/Town**
   **State**
   **Zip Code**

   **Home Phone ( )**
   **Cell Phone ( )**
   **Email**

   **Social Security # (REQUIRED)**
   **Other Insurance?**
   **Other Insurance Company Name**

   **Are you covered by Medicare?**
   - [ ] Y
   - [ ] N

   **Part A Effective Date**
   **Part B Effective Date**
   **Part D Effective Date**
   **Medicare #**
   **Actively Working?**
   - [ ] Y
   - [ ] N

   **Date of Birth**

3. **Member 2**

   **Please Check One:**
   - [ ] Spouse
   - [ ] Domestic Partner
   - [ ] Divorced Spouse (court ordered)
   **Plan Type:** [ ] Dental

   **First Name**
   **M.I.**
   **Last Name**
   **Sex**
   **Date of Birth**

   **Social Security # (REQUIRED)**

   **Phone ( )**
   **Other Insurance?**
   **Other Insurance Company Name**

   **Are you covered by Medicare?**
   - [ ] Y
   - [ ] N

   **Part A Effective Date**
   **Part B Effective Date**
   **Part D Effective Date**
   **Medicare #**
   **Actively Working?**
   - [ ] Y
   - [ ] N

   **Date of Birth**

4. **Your Eligible Dependents (Member 3, 4, and 5)**

   **Dependent’s First Name**
   **M.I.**
   **Last Name**
   **Sex**
   **Date of Birth**

   **Social Security # (REQUIRED)**

   **Full-time student and aged 19 or older**
   - [ ] Y
   - [ ] N
   - [ ] Disabled and aged 26 or older
   **Plan Type:** [ ] Dental

   **Dependent’s First Name**
   **M.I.**
   **Last Name**
   **Sex**
   **Date of Birth**

   **Social Security # (REQUIRED)**

   **Full-time student and aged 19 or older**
   - [ ] Y
   - [ ] N
   - [ ] Disabled and aged 26 or older
   **Plan Type:** [ ] Dental

   **Dependent’s First Name**
   **M.I.**
   **Last Name**
   **Sex**
   **Date of Birth**

   **Social Security # (REQUIRED)**

   **Full-time student and aged 19 or older**
   - [ ] Y
   - [ ] N
   - [ ] Disabled and aged 26 or older
   **Plan Type:** [ ] Dental

   **Total # of dependents:**

5. **Signature (Employer & Employee)**

   The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in “Our Commitment to Confidentiality,” Blue Cross and Blue Shield’s notice of privacy practices.

   **Employee’s Signature**
   **Date**
   **Employer’s Signature**
   **Date**

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1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.
3. **Student Coverage:** If you are seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form.