



LifeMap Assurance Company
 100 SW Market Street
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 Portland, OR 97207-1271
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Group Vision Insurance Employee Enrollment and Change Form

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

Employer Name Gooding School District #231	Group Number
<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"/> Cancellation For any change to existing enrollment, cancelation, or continuation of coverage, please indicate reason below.	

Employee's Name (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Social Security Number	<input type="checkbox"/> Married or Domestic Partner <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 to You	Enroll for coverage
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> 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:

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

Add Dependent(s) due to	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage or 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 or Domestic Partner <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

Cancellation 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) <input type="checkbox"/> Self <input type="checkbox"/> Spouse or Domestic Partner <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 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