CANYON-OWYHEE SCHOOL SERVICE AGENCY #555

109 Penny Lane – Wilder, Idaho 83676-5207
www.cossaschools.org
Phone (208) 482-6074 – Fax (208) 482-7904

Welcome back! I hope that you had a good summer and are feeling refreshed and ready for the upcoming school year. The COSSA Human Resources Department is responsible for maintaining an employee record for every COSSA employee and as such there are a few papers that need filled out or updated for your file. Please use your legal name and not a nickname when filling in your information.

PLEASE READ THE FOLLOWING CAREFULLY

1. The second page of this document is a fillable form that will automatically fill in the repetitive information that is asked for throughout the documents. Please fill out completely.
2. You will need to scroll through each of the documents to check for information and boxes that need to be filled out separately to insure that all of the pertinent information has been filled in.
3. After all of the forms are completed to your satisfaction you can then print the forms to physically sign and turn in to the Human Resource Department.
4. Regarding Health Insurance, you will need to turn in a Blue Cross Enrollment form letting us know which health plan you would like to participate in (which is only allowable during open enrollment and will become effective as of September 1, 2024). However, if you are waiving the insurance for the 2024-2025 school year you will need to fill out a Waiver form. These forms are available on our website at: https://www.cossaschools.org/employee-forms

Please let us know if you have any questions and feel free to visit our website where you can view and print other employee forms and information as needed: https://www.cossaschools.org/employee-forms

Again, welcome back and have a great school year!

Sincerely,

Miren Lowry & Mandy Pascale
COSSA Human Resource Department

Full Legal Name Social

First Name

Middle Initial

Last Name

Security Number

Today's Date

Work Phone

Email Address

Physical Address

City

State Abbreviation

Zip

Home Phone

Mailing Address

City

State Abbreviation

Zip

Cell Phone

Blank

Gender

City, State, Zip

Cossa Human Resource Office
109 Penny Lane, Wilder, ID, 83676
(208) 482-6074 • Fax: (208) 482-7904
http://www.cossaschools.org

Personal Liability Insurance Acknowledgment

This is to acknowledge that I have been provided information regarding professional liability insurance in compliance with Title 33-524, Idaho Code, in which school districts shall provide information to their employees (all certificated and noncertified staff) regarding professional liability insurance for educators. A list of providers can be found on the COSSA website and can be accessed at https://docs.wixstatic.com/ugd/a04748_3c24ec0c68504b719177e7505d18bb0a.pdf

Personnel Handbook Acknowledgment

This is to acknowledge that I have been advised of the web-based Canyon-Owyhee School Service Agency Personnel Handbook which can be accessed on the COSSA web page at www.cossaschools.org

I hereby acknowledge receipt of the COSSA Personnel Manual (a copy of the Personnel Handbook is posted on the COSSA website for all employee and stakeholder review). I realize that the manual contains agency policies and procedures, but is not intended to be a complete and exhaustive explanation of the same. I also understand that said policies and procedures are subject to change; that I am to familiarize myself with its contents; and that I am to abide by the policies and procedures stated herein and of the agency. Complete COSSA Policies are available for review at the COSSA Administrative Office and are additionally posted on the COSSA website.

I further understand and agree that this manual does not constitute a contract of employment.

The policies and procedures described in this manual may be revised from time to time through the discretion of the COSSA Board of Trustees. Copies of individual policies and procedures may be printed directly from the website, requested from an administrator, or requested from the COSSA Human Resources Office.

COSSA employees will take a Personnel Handbook lesson and quiz annually using the SafeSchools training platform.

COSSA would like all employees to be familiar will all policies and procedures but especially aware of:

Policy 111 - Parental Rights
Policy 113 - Student and Family Privacy
Policy 116 - Public Records Request
Policy 210 - Employee Purchase
Policy 309 - Sick Leave Bank
Policy 310 - Family and Medical Leave
Policy 311- Sexual Harassment
Policy 8200 - Wellness

Policy 313 - Drug Free Workplace
Policy 406 - Student First Aid
Policy 415 - Service Animals
Policy 420 - Safe Environment
Policy 421 - Students with Head Lice
Policy 5210 - FLSA and Work Day
Policy 5250 - Certified Personnel Grievance
Policy 5800 - Classified Personnel Grievance
Policy 7235 - Time and Effort

_____
Employee's Signature

_____
Employee's Printed Name

_____
Date

CANYON-OWYHEE SCHOOL SERVICE AGENCY (COSSA)

INSURANCE BENEFIT

Acknowledgment

School Year: 2024-2025

In compliance with the Affordable Care Act (ACA) passed by Congress and signed into law in 2010, Canyon-Owyhee School Service Agency is required to provide a Summary of Benefits and Coverage (SBC) and Glossary of Health Coverage and Medical Terms to all employees. A copy of each of these is available to all employees online at www.cossaschools.org.

In compliance with the Affordable Care Act (ACA) and by my signature below, I verify that I have been informed and received information regarding health coverage options by Canyon-Owyhee School Service Agency, and I acknowledge that Canyon-Owyhee School Service Agency has disclosed to me the attached Summaries of Benefits and Coverage (SBC's) for each available option and the attached Glossary of Health Coverage and Medical Terms, as required by law.

_____ _____

Signature Date

Print Name:_____

CEA Membership

Name: _____

☐ Yes, I would like to join COSSA Education Association. I agree to have the $10.00 dues deducted (one time) from my paycheck.

☐ No, I am not interested at this time.

_____ _____

Signature Date

COSSA EDUCATION ASSOCIATION
SICK LEAVE BANK

Continuing Membership (3+ Years)

In order to continue membership with the COSSA Education Association (CEA) sick leave bank, a 1/2 day of sick leave must be donated.

☐ I do want to remain a member and do hereby authorize a 1/2 day of my sick leave to be donated to the COSSA Education Association (CEA) Sick Leave Bank.

☐ I do not wish to continue my membership with the COSSA Education Association (CEA) Sick Leave Bank and request that my membership be stopped.

NOTE: In order to continue membership with the Sick Leave Bank, this form must be returned no later than the 31st day of August after returning from summer break.

Printed Name _____

Signed_____

Date_____

COSSA EDUCATION ASSOCIATION
SICK LEAVE BANK

New Membership (2 Years)

In order to be eligible for sick leave bank benefits, two days of sick leave must be donated and you must have been employed with Canyon-Owyhee School Service Agency for at least one year.

☐ I do want to be a member and do hereby authorize two days of my sick leave to be donated to the COSSA Education Association Sick Leave Bank.

☐ I do not want to be a member of the COSSA Education Association Sick Leave Bank.

NOTE: In order to be eligible for the Sick Leave Bank, this form must be returned within 30 days of employment.

Printed Name _____

Signed _____

Date _____

CEA SCHOLARSHIP
PAYROLL DEDUCTION FORM

I (print name) _____ would like to support the COSSA Education Association (CEA) scholarship fund by donating through an automatic payroll deduction as follows:

Monthly (amount) _____ One-time donation (amount) _____

_____ _____
Signature Date

Statewide Schools ASC Health/Dental/Vision Enrollment Application

Blue Cross of Idaho

Requested Effective Date *(subject to Blue Cross of Idaho approval)* ______________

Group Number 10003727-R005

❑ **PPO Medical** 1000/2000 Option 1

❑ HSA BlueSM Option 2

❑ Managed Care Medical POS

❑ **Dental Blue Connect**

❑ PPO Dental

❑ **Vision**

Please complete each section of this application in ink.

Applicant Information (Employee)

Your Name (first, initial, last)	Blue Cross ID No. (if currently enrolled)	Social Security No.	Date of Birth	❑ Male ❑ Female
Mailing Address	City, State, Zip Code		Phone Number	
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Full-time Hire Date	Name of Employer CANYON-OWYHEE SCHOOL SERVICE AGENCY	Job Title	Email Address

Dependent Information (If you choose not to enroll all your eligible family members, you must complete a waiver form.)

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Male/Female	Type of Enrollment	
Applicant/Employee		**SELF**		❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No	
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No	*Office Use (PCP)*

Type of Enrollment

Health Coverage *(check one)*	**Dental Coverage** *(check one)*	**Vision Coverage** *(check one)*
❑ Self only	❑ Self only	❑ Self only
❑ Self and spouse	❑ Self and spouse	❑ Self and spouse
❑ Self, spouse and dependents	❑ Self, spouse and dependents	❑ Self, spouse and dependents
❑ Self and one dependent	❑ Self and one dependent	❑ Self and one dependent
❑ Self and two or more dependents	❑ Self and two or more dependents	❑ Self and two or more dependents

Change Request

Please indicate reason for change in current enrollment below:

❑ Involuntary loss of group coverage ❑ Marriage ❑ Birth ❑ Adoption

❑ Court order (copy of court order required)

Other ____

Date event occurred ______________________
mm dd yy

Please read the reverse side and sign and date this application. **OVER ☛**

FOR OFFICE USE ONLY

Group Number	*Subgroup*	*Effective Date*	*Plan ID*			*Class*	*Reason Code*
			M	*D*	*V*		

Auditor _________

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Disability Information

Are you or any of your dependents currently disabled? ❑ **YES** ❑ **NO**

Nature of Disability

Name of Disabled Person

Physician's Name *Physician's Phone Number*

Date of Disability

Physician's Address

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- Blue Cross of Idaho may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- I acknowledge and understand my health plan 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***bcidaho.com.***
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Blue Cross of Idaho.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X *Applicant's Signature*

Date