EMPLOYEE ENROLLMENT FORM FOR GROUP COMPREHENSIVE HEALTH INSURANCE

Employer Information			
Name of Employer Shelley Joint School Distrct No. 60			
Date of Hire	**Effective Date**		
Applicant Information			
First Name	**Middle Name**	**Last Name**	
Date of Birth (mm/dd/yyyy)	**Social Security Number**	**Gender** [ ] Male [ ] Female	
Mailing Address	**City**	**State**	**Zip Code**
Primary Phone Number	**Secondary Phone Number**	**Email Address**	

Race (Optional)

[ ] American Indian or Alaskan Native
[ ] Asian or Pacific Islander
[ ] Asian Pacific American
[ ] Black
[ ] Black (Non-Hispanic)
[ ] Caucasian
[ ] Hispanic
[ ] Mutually Defined
[ ] Native American
[ ] Native Hawaiian
[ ] Other Race or Ethnicity
[ ] Pacific Islander
[ ] Subcontinent Asian American
[ ] White (Non-Hispanic)

Waiver of Coverage - You must complete this section if you DO NOT want coverage.

[ ] I am declining coverage due to the existence of other coverage:
[ ] Group Plan [ ] Individual Plan [ ] Tri-Care [ ] Medicaid
[ ] Continuation/COBRA [ ] Medicare [ ] VA Eligible [ ] Children's Health Insurance Program
[ ] I (and/or family members) choose to be without coverage.

Acceptance of Coverage

[ ] I wish to enroll for this group coverage.

Benefit Plan Selection:

☐ $500 PPO ☐ $3,000 HSA

Dependents to be insured *(Indicate all dependents to be insured under the Group Policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant [ ] Spouse [ ] Domestic Partner [ ] Dependent Child		
First Name	**Last Name**	**Date of Birth**	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		
First Name	**Last Name**	**Date of Birth**	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		
First Name	**Last Name**	**Date of Birth**	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant Dependent Child		

Has any person to be covered, who may legally use tobacco under federal or state law, used any tobacco product on an average of four or more times per week within the past 6 months (this does not include tobacco use for religious or ceremonial use)? [ ] Yes [ ] No If "Yes", please provide information below

Name	**Currently Using Tobacco Product (s) (Y/N)**	**Type of Tobacco Product Used**	**Willing to participate in a cessation program? (Y/N)**

To the best of my knowledge and belief, the information I have provided on this form is correct and complete. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I understand that premiums for my coverage under the group policy will be remitted to the Montana Health Cooperative by my employer. If I must contribute to the premium for my coverage, I understand that arrangements for payroll deduction will be made by my Employer.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison and may result in denial of coverage under the Group Policy.

_____ _____

Signature of Employee Date signed