Southeast Dubois County School Enrollment Form 2023

This Enrollment form lists your benefit options and corresponding payroll deductions. Use this form to elect or decline your benefit options. PLEASE PRINT.

EMPLOYEE INFORMATION

Name		**Gender**	☐ Male ☐ Female
Street Address		**Birth date** (MM/DD/YYYY)	/ /
City		**Social Security Number**	- -
State			
Zip		**Date Employed**	/ /
Cell Phone Number		**Department**	
Home Phone Number		**Employee Status**	☐ Active Full-Time ☐ Active Part-Time
Email Address		**Hours worked per week**	
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Never been married	**Occupation**	
Authorized to work/reside in the United States	☐ Yes ☐ No	**Annual Salary/Income**	

REASON FOR ELECTING OR CHANGING BENEFITS

Open Enrollment Period	☐ Yes ☐ No	**Status Change**	☐ Birth	☐ Spouse lost coverage under another plan
New Employee	☐ Yes ☐ No		☐ Adoption	☐ Spouse changed coverage under another plan
Address Change	☐ Yes ☐ No		☐ Marriage	☐ Dependent lost coverage under another plan
			☐ Divorce	☐ Other
			☐ Death	

BENEFIT ELECTIONS

Pay Cycle: Bi-weekly 26 payrolls/paychecks per year – contributions deducted from 24 of the 26 payrolls. If electing benefits after open enrollment period deductions are for remaining paychecks in year only.

MEDICAL BENEFITS

ELECTION		PLAN A – $3,000 Deductible		PLAN B –$5,000 Deductible		PER PAY AMT
☐	DECLINE BENEFITS					
☐	SINGLE COVERGE	☐ $108.00		☐ $25.00		
☐	EMPLOYEE + CHILD(REN) COVERAGE	☐ $284.00		☐ $80.00		
☐	EMPLOYEE + SPOUSE COVERAGE	☐ $328.00		☐ $85.00		
☐	FAMILY COVERAGE	☐ $452.00		☐ $100.00		
					TOTAL AMOUNT PER PAY	$

DEPENDENT INFORMATION

You need to provide information on all dependents whom you wish to cover for the benefits elected. In general, eligible dependents include your spouse and dependent children to age 26. See the definition of a dependent and other eligibility requirements in the plans Summary Plan Description booklet.

	Name (First, Mi, Last)	SSN	Gender	Birth Date	Employed	Disabled	Coverage (check all that apply)			
SPOUSE		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			
CHILD		- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical			

OTHER COVERAGE INFORMATION

As of your eligibility with SE Dubois Schools, do you or any eligible dependents have other medical coverage? Included Medicare/Medicaid?	☐ Yes ☐ No If yes, please complete the following:
As of your eligibility with SE Dubois Schools, do you or any eligible dependent age 19 or above have other medical coverage available through another employer that has not been elected?	☐ Yes ☐ No If yes, please complete the following:
Name of Employer providing other coverage	
Employer's phone number	
Insurance Carrier Name	
Insurance Carrier Address	
Insurance Carrier Phone Number	
Type of Coverage	☐ Employer Group Health Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid ☐ Other (please explain):____________________________

List all persons covered under other coverage and their coverage type under		
Name (First, Mi, Last)	List Type of other coverage	Effective Date of other coverage
SPOUSE	☐ Medical	/ /
CHILD	☐ Medical	/ /
CHILD	☐ Medical	/ /
CHILD	☐ Medical	/ /
CHILD	☐ Medical	/ /
CHILD	☐ Medical	/ /

ACKNOWLEDGEMENT/AUTHORIZATION

Proof of creditable coverage must be supplied for all new employees and their dependents age 19 and above. Such proof may be obtained from your prior insurance carrier. I hereby apply for or decline Group Benefits(s) for which I am eligible under this Employer.

I hereby apply for or decline Group Benefits(s) for which I am eligible under this Employer. In addition, I authorize my employer to reduce from each paycheck, on a pre-tax basis, the contributions shown above for benefits elected. (Note: In accordance with IRS code, some benefits may be after-tax.)
If you do not authorize your employer to reduce from each paycheck on a pre-tax basis, the contributions shown above for benefits elected, please check here: ☐

If I participate in the Section 125 Flexible Benefit Plan, I further understand that (a) because of the pre-tax reduction in my salary, there could be a slight reduction in my social security benefits available at retirement and (b) my employer cannot be responsible for any tax liabilities which may subsequently occur as a result of my participation in the Section 125 Flexible Benefit Plan. If I participate in the voluntary products, my employer may continue to reduce on a pre- or post-tax basis as previously enrolled until an authorized change is made during an open enrollment period or major life event. I understand that I have the right to change my elections if (a) I experience a "major life event" such as marriage, loss of coverage, addition/deletion of dependent; or (b) the amount of premiums that I contribute during the plan year changes.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employee's Signature _____ Date _____

WAIVER

I have been given the opportunity to apply for Group Benefit(s) as offered by my employer and after careful consideration, have decided not to take advantage of this offer. Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employee's Signature _____ Date _____