OSSEO AREA SCHOOLS
ISD 279

2023 Health Insurance
Non EM-O Employees

SECTION 1 – EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name	First	MI	Social Security # - -
Street Address			Phone Number
City	State	Zip Code	Date of Birth / Employee #
Contract Group	☐ Single ☐ Married		Employee Hire Date

SECTION 2 – REASON FOR CHANGE/ENROLLMENT

- ☒ Open Enrollment
- ☐ Adding Dependents
- ☐ Dropping Dependents
- ☐ Declining Coverage
- ☐ Change Name/Address
- ☐ Other:_____

SECTION 3 – NEW PLAN (MEDICAL)

☐ High Plan ☐ Value Plan ☐ HSA Plan	☐ Single ☐ Single + 1 ☐ Family ☐ Decline	Effective Date: _____

SECTION 4 – DEPENDENT INFORMATION

Add	Drop	Relationship to Employee	First Name, Middle Initial (last name only if different from employee)	Gender	Date of Birth (required)	Social Security #
☐	☐	Employee				
☐	☐					
☐	☐					
☐	☐					
☐	☐					

SECTION 5 – EMPLOYEE SIGNATURE

I understand that this election cannot be revoked or changed until the next open enrollment period, unless there is a loss of eligible or life event. The change must be made within 30 days from the date of the life event.
(Please contact your Human Resources Business Partner or refer to the benefits booklet for the life event information.)

_____ _____
EMPLOYEE SIGNATURE DATE SIGNED

☐ My Spouse is also employed with the district

For HR Use Only EFP: UMR: HRS: Audit:

Deductions: ☐ Full Year ☐ August ☐ September ☐ October