MADISON METROPOLITAN SCHOOL DISTRICT

Human Resources | 545 West Dayton St. | Madison, Wisconsin 53703-1967 | 608-663-1693 | hr.mmsd.org

Jennifer Trendel, *Senior Executive Director of Human Resources* | Lisa Kvistad, *Interim Superintendent of Schools*

2023 Madison Metropolitan School District Retiree Open Enrollment Plan Election form

Full Name: ____________________

Birthdate: ____________________

Email: ____________________

Address: ____________________

____

ADD/REMOVE DEPENDENTS FROM ALL COVERAGE

I wish to **add/delete** a dependent from ***all*** of my coverage(s), please note individual coverage dependent removal can be done below under the specific plan:

- ☐ Add
- ☐ Remove

***Please provide legal paperwork if adding a new dependent to any of the insurances coverages (i.e., birth certificate, marriage certificate, etc). If you wish to change your beneficiary please complete this form and return to the retirement department (retirement@madison.k12.wi.us) : https://www.madison.k12.wi.us/fs/resource-manager/view/8b80e3e3-25bc-413f-9575-4a1271e2866d*

Dependent Information:

Name of Dependent: ____________________

SSN: ____________________

DOB: ____________________

Relationship: ____________________

HEALTH INSURANCE

I wish to make changes to my current health insurance coverage:

- ☐ Yes
- ☐ No

If yes, I wish to change my Health Insurance to:

- ☐ Single coverage
- ☐ Family coverage
- ☐ Waive coverage
- ☐ I wish to keep my current coverage.

If yes, I wish to change my Health insurance carrier to:

- ☐ Dean
- ☐ Quartz
- ☐ I wish to keep my current coverage.

I wish to enroll a new dependent on my Health Insurance plan:

Name of Dependent: ____________________

SSN: ____________________

DOB: ______________________________

Relationship: ______________________________

**Please provide legal paperwork if adding a new dependent, birth certificate or marriage certificate.*

DENTAL INSURANCE

I wish to make changes to my current dental insurance coverage?

- ☐ Yes
- ☐ No

If yes, I wish to change my Dental Insurance to:

- ☐ Single coverage
- ☐ Family coverage
- ☐ Waive coverage
- ☐ I wish to keep my current coverage.

I wish to enroll a new dependent on my Dental Insurance plan:

Name of Dependent: ______________________________

SSN: ______________________________

DOB: ______________________________

Relationship: ______________________________

**Please provide legal paperwork if adding a new dependent, birth certificate or marriage certificate.*

LIFE INSURANCE

If you currently have Life Insurance coverage, do you wish to cancel this coverage?

- ☐ Yes
- ☐ No

LONG-TERM CARE INSURANCE

If you currently have UNUM Long Term Care coverage, do you wish to cancel this coverage?

- ☐ Yes
- ☐ No

ACKNOWLEDGEMENT & AUTHORIZATION

I understand and agree that I cannot change or revoke this election(s) at any time during the 2024 plan year unless I have a qualifying life event such as a change in family status including marriage, divorce, death of a spouse or child, birth or adoption of a child, or termination of employment of a spouse resulting in a loss of coverage.

Signature: ____

Date: ____

Please mail your completed form to:

Madison Metropolitan School District

Attn. HR Benefits

545 West Dayton Street

Madison, WI 53703