# 2024 OPEN ENROLLMENT | CHANGE FORM

Effective Date: ________________

Submit before 4:00 pm on November 3, 2023 to:

**Human Resources**
**104 Fifth Avenue South**
**South St. Paul, MN 55075**
**651.457.9496**

## A. EMPLOYEE INFORMATION

| Last Name | First Name | Middle Initial | Birthdate | Gender |
|---|---|---|---|---|
| | | | | |

| Home Phone | Work Phone ( ) | Marital Status | ❑ Single ❑ Divorced | ❑ Legally Married ❑ Legally Separated |
|---|---|---|---|---|

| Last 4-digits of Social Security Number | Position | Date of Hire N/A during Open Enrollment |
|---|---|---|

## B. CANCELLATION OF COVERAGE

**Cancel Coverage**

❑ Cancel all coverage
❑ Cancel all dependent coverage only
❑ Cancel only dependent(s) listed in section D.

Cancel Medical (M), Dental (D) or (Both): ______

**Reason for Cancellation**: *Open Enrollment*

Last date of eligibility: ______________________________

(Open Enrollment Cancellations end 12/31/2022)

## C. CHANGE PLAN or COVERAGE

**Change Medical Plan FROM:**

❑ $500-$35 Copay Plan ❑ Single
❑ $1500-$35 Copay Plan ❑ Single + One
❑ $3200 HSA Plan ❑ Family

**Change Medical Plan TO:**

❑ $500-$35 Copay Plan ❑ Single
❑ $1500-$35 Copay Plan ❑ Single + One
❑ $3200 HSA Plan ❑ Family

**Change Dental Plan FROM**:

❑ Single
❑ Family

**Change Dental Plan TO:**

❑ Single
❑ Family

**Addition to Coverage**

❑ Add Dependent(s) as listed in section D.

**Reason for Change:**

*Open Enrollment*-Comments:

## D. FAMILY INFORMATION

| **List all family members to be covered.** | **Gender M or F** | **Birthdate Mo./Day/Year** | **Relationship to Applicant** | **Social Security Number** | **Cancel/Enroll in: (M) or (D) or (Both)** |
|---|---|---|---|---|---|
| **Other Dependents** Name (First, Middle, Last) | | | | | |
| **Other Dependents** Name (First, Middle, Last) | | | | | |
| **Other Dependents** Name (First, Middle, Last) | | | | | |

## E. ACKNOWLEDGEMENTS

I understand that misstatements, material misrepresentations or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am eligible. I authorize any physician, other health professionals, hospitals and other health care institutions, to provide the carrier's contracted physicians, consulting health professionals, utilization review organizations, and independent claim administrators with whom the carriers have contracted, information concerning health care advice, treatment or supplies, including those involving mental illness, provided me and/or my dependents, relating to coverage under these plans. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on the carriers by federal or state law. The carriers may provide South St. Paul Schools with any benefit calculation used in the payment of these claims for the purpose of reviewing the experience and operation of the policy or contract. My signature below affirms that all information and statements provided on the form are full, complete and true to the best of my knowledge.

Signature: Date: