South St. Paul Public Schools

2024 OPEN ENROLLMENT | NEW ENROLLMENT FORM

Effective Date: January 1, 2024

Submit before 4:00pm 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

Street Address	Apt. No.	City	State	Zip Code

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. MEDICAL AND DENTAL INSURANCE

Application for Medical Plan:

❑ $500-$35 Copay Plan
❑ $1500-$35 Copay Plan
❑ $3200 HSA Plan

❑ Single
❑ Single + One
❑ Family

OPEN ENROLLMENT: ❑ No Medical Changes

Application for Dental Plan:

❑ Single
❑ Family

OPEN ENROLLMENT: ❑ No Dental Changes

C. FAMILY INFORMATION

List all family members to be covered.	**Gender M or F**	**Birthdate Mo./Day/Year**	**Relationship to Applicant**	**Social Security Number**	**Enrollment in: (M) or (D) or (Both)**
Employee Name (First, Middle, Last)	N/A	N/A	**SELF**	N/A	
Legally Married Spouse Name (First, Middle, Last)			**SPOUSE**		
Other Dependents Name (First, Middle, Last)					
Other Dependents Name (First, Middle, Last)					
Other Dependents Name (First, Middle, Last)					

Dependent children are covered to age 26, Handicapped dependents over age 26 that are financially dependent are eligible for coverage. Please fill in the information noted here if applicable.

Name

Handicapped Yes or No

Name of family members covered by Medicare	Medicare Number	Part A Effective Date	Part B Effective Date

D. 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: