



# HOOSIER HEARTLAND SCHOOL TRUST EMPLOYEE ENROLLMENT FORM

<b>Monroe Gregg School Use Only</b>		
Employee Date of Hire:	Employee Occupation:	Coverage Effective Date:
Is Income Reported by W-2?	Hours Worked Per Week:	Retirement Date:

**Section A – Waiver of Coverage (This section must be completed for employee and / or any eligible dependent not enrolling the group health plan when initially eligible due to coverage elsewhere)**

Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage

I certify that I have been given an opportunity to apply for group health coverage through the Trust and I am declining as indicated above. I understand that I will be able to enroll in the future only during the next annual open enrollment period, OR if I or my eligible dependent(s) experience a qualifying event as defined by HIPAA guidelines. I also understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents at that time. All enrollment forms must be received within 31 days of the event.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section B – Medical Coverage Selection Information**

Circle One	Active 0037	Retiree 0041	COBRA 0045	Active 0038	Retiree 0042	COBRA 0046	Active 0039	Retiree 0043	COBRA 0047	Active 0040	Retiree 0044	COBRA 0048
Employee	<input type="checkbox"/>	PPO 1		<input type="checkbox"/>	PPO 2		<input type="checkbox"/>	HDHP 1		<input type="checkbox"/>	HDHP 2	
EE/Child(ren)	<input type="checkbox"/>	PPO 1		<input type="checkbox"/>	PPO 2		<input type="checkbox"/>	HDHP 1		<input type="checkbox"/>	HDHP 2	
EE/Spouse	<input type="checkbox"/>	PPO 1		<input type="checkbox"/>	PPO 2		<input type="checkbox"/>	HDHP 1		<input type="checkbox"/>	HDHP 2	
Family	<input type="checkbox"/>	PPO 1		<input type="checkbox"/>	PPO 2		<input type="checkbox"/>	HDHP 1		<input type="checkbox"/>	HDHP 2	

**Section C – Employee/Application Information (all fields must be completed)**

First Name	MI	Last Name	Social Security #	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm/dd/yyyy	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Home Address (include PO Box if applicable)			City	State		Zip
Home Phone ( )			Work Phone ( )			
Email Address				Document Preference <input type="checkbox"/> NO PREFERENCE <input type="checkbox"/> ONLINE <input type="checkbox"/> PAPER		

**Section D – Spouse Information (all fields must be completed)**

First Name	MI	Last Name	Social Security #	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm/dd/yyyy
Is your spouse employed?					
<input type="checkbox"/> Yes      If yes, please provide name of employer: _____ <input type="checkbox"/> No					
Does your spouse have medical coverage through his/her employer?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					

Section E – Family Information – (all fields must be completed for each covered dependent)					
First Name	MI	Last Name	Social Security #	Relationship / Sex: <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	Date of Birth mm/dd/yyyy

**Section F – Other Health Coverage**

List yourself and any family members to be enrolled in this plan who will be covered by other health coverage on this plan's effective date:

Provide name & address of insurance carrier: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Group/Account/Policy ID Number: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

If you and/or your dependent(s) are enrolled in Medicare or Medicaid, please complete the following:

Enrollees Name:	Medicare/Medicaid ID #	Medicare Part A Effective Date:	Medicare Part B Effective Date:
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**Section G – Prior Health Coverage**

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years?

Yes (*complete information below*)

No

List yourself and any other family members who have had prior coverage:	Name of Insurance Carrier:
	Group/Account/Policy ID Number:
	Coverage Effective Date:
	Coverage Termination Date:
	Reason for Termination:
	<input type="checkbox"/> Divorce/Legal Separation
	<input type="checkbox"/> Death of Spouse
	<input type="checkbox"/> COBRA Coverage Exhausted
	<input type="checkbox"/> Termination of Employment
	<input type="checkbox"/> Employer Premium Contribution Ceased
	<input type="checkbox"/> Other - Please explain _____

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. All enrollments must be submitted within 31 days of the qualifying event. All required documentation must accompany this form in order to process the enrollment.

By signature, I declare that the information provided is complete and correct. By electing coverage under this Plan, I also agree to have the applicable premium deductions made. I accept that I am responsible to notify my employer of any change that would make me or any dependent ineligible for benefits under the Trust group health plan.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your coverage is issued by a multiple employee welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

HHST Office Use Only			
Spouse: Marriage Certificate _____	Child: Birth Certificate _____	UHC _____	2020/2021
Current Tax/Bill Doc _____	Court Order/Adoption Decree _____		