enrollment / change / waiver Group Insurance Form

Oakes Public School District #41

1 to enroll

Policy: ☐Health-BlueSaver ☐Health-CompChoice ☐Dental ☐Vision ☐Life ☐FSA

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number_____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Date of hire_____ ☐ Rehire: Rehire date _____

Occupation_____Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

Are you covered under another insurance plan? ..... Employee: ☐Yes ☐No Dependents: ☐Yes ☐No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	add	drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐
6	☐	☐					☐

Life Insurance Only:

Coverage Elections: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child(ren), if applicable. Spouse and child(ren) life and/or AD&D coverage amounts cannot exceed 100% of your life and/or AD&D coverage amounts.

Any coverage amounts left blank will result in a coverage amount of $0, including current coverage.

Total amount of coverage: $ _____

Life: ☐ Myself $ _____ ☐ Spouse $ _____ ☐ Child(ren) $ _____

AD&D: ☐ Myself $ _____ ☐ Spouse $ _____ ☐ Child(ren) $ _____

Beneficiay(ies) Name (Last, First, MI)	Relation to You	Social Security Number	Date of Birth	Address or Telephone Number	Benefit%
				Total must equal 100%	
Contingent Benficiary(ies)					
				Total must equal 100%	

HSA Election

Employee Contribution – Per Pay Period Amount $ _____

*I represent that I am covered under a high deductible health plan; I am not covered by any other health plan that is not a high deductible health plan; I am not enrolled in Medicare; I cannot be claimed as a dependent on another person's tax return; and I have read the program information. _____ initial

FSA Election

	Medical FSA	Dependent Care FSA
Annual Election	$	$
Number of Pay Periods		
Pay Period Amount	$	$

*My reduction is for one flex plan year and I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account. _____ initial

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2 to change

Policy: ☐Health-BlueSaver ☐Health-CompChoice ☐Dental ☐Vision ☐Life ☐FSA ☐ HSA

☐ Name Change New Name_____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION.

Policy: ☐Health-BlueSaver ☐Health-CompChoice ☐Dental ☐Vision ☐Life ☐ FSA ☐ HAS

I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐myself ☐spouse/domestic partner ☐child(ren) only ☐spouse/domestic partner and child(ren)

because _____

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Please Sign Review your certificate carefully. As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

X _____ _____

Employee Signature (do not print) Date