ENROLLMENT FORM

WMHIP
Transforming healthcare together

Name of employer/plan sponsor:	Group #:	Plan choice: _____$500/$1000
WMHIP – IONIA PUBLIC SCHOOLS		_____$1400/$2800 HSA _____ $2000/$4000 HSA

Check one: ☐ OPEN ENROLLMENT

Reason for change (check all that apply):	**Date of hire:**
☐ Initial Eligibility Following Hire ☐ Open Enrollment ☐ Status Change: _____ ☐ Other: _____	**Occupation:** **Hours worked weekly:** **Effective date of coverage or change:** JANUARY 1, 2018

Employee Name (last, first, middle initial):	**Sex:** ☐ Female ☐ Male	**Date of Birth:**	**Social Security Number:**
Street Address:	**Telephone (including area code):** Work:		Home:
City:	**State:**		**ZIP Code:**

Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Sex	Termination Date
Spouse:				☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	

Employee certification and signature:

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a "change in status" or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.