2025 HealthPartners Open Enrollment Correction Request Form

Saint Paul Public Schools
Plan Year 2025
PDF Fillable Form

Employee Full Name: (Last, First, MI)	Date of Birth: (Required)	HealthPartners **Employees Enrolled in Medica Plans** **Plan Year 2025 Enrollment Correction** **Request Due by Friday 11/22/24 at 11:59 PM** **Requests received after that time will not be accepted.**	Employee ID:
Street Address:	Last 4 of SSN:		Bargaining Unit (Union):
City, State, Zip Code:	◉ Male ○ Female		Emergency Contact Name:
Primary Phone Number:	Email:		Relationship:
Marital Status: ◉ Single ○ Married If married is your spouse a SPPS employee? ○ Yes ◉ No			Emergency Contact Phone:
If yes, provide spouse name and spouse employee ID Full Name: ID:			

Effective Date January 1, 2025

Make your selections below based on the elections you want for 2025

Medical Insurance – HealthPartners (All Fields Required)

Select Plan

- ☐ Copay plan - Select Network
- ☐ Copay Plan - Open Access
- ☐ HSA- Select Network
- ☐ HSA - Open Access

Select Coverage Level:

- ☐ Employee Only
- ☐ Employee Plus One
- ☐ Family

☐ *I elect to waive medical coverage *Only for PT ee's, or FT ee's in AFSCME, NS, PEA, or TA

DentalInsurance - MetLife

Check coverage level desired:

- ☐ Employee Only
- ☐ Employee Plus One
- ☐ Family

Vision – EyeMed

Check coverage level desired:

Note: Your vision exam is covered under your medical plan (if covered). EyeMed is for glasses or contacts.

- ☐ Employee Only Coverage
- ☐ Employee Plus One
- ☐ Family Coverage
- ☐ Waive Coverage

Spending Accounts

If electing for plan year 2025

- Health Savings Account Form
- Flexible Spending Medical (FSA) or
- Dependent Flexible Spending (FSAD)

You must complete a separate form.
Forms are attached to this PDF

Completed Enrollment Correction Request must be received in the SPPS Benefits Office by November 22, 2024 by 11:59 PM

E-Mail Forms to benefits@spps.org or Fax to 651-305-4259

Legal Dependent Information - Required

Based on your selections above use the drop down menu in the dependent area to show the coverage for each dependent.

Full Name of Legal Dependent	Legal Dependent	Sex	Medical	Dental	Vision
First Name:	-	-	-	-	-
Middle Name:	**Date of Birth** (Required)	**Social Security #** (Required)			
Last Name:					

Full Name of Legal Dependent	Legal Dependent	Sex	Medical	Dental	Vision
First Name:	-	-	-	-	-
Middle Name:	**Date of Birth** (Required)	**Social Security #** (Required)			
Last Name:					

Full Name of Legal Dependent	Legal Dependent	Sex	Medical	Dental	Vision
First Name:	-	-	-	-	-
Middle Name:	**Date of Birth** (Required)	**Social Security #** (Required)			
Last Name:					

Full Name of Legal Dependent	Legal Dependent	Sex	Medical	Dental	Vision
First Name:	-	-	-	-	-
Middle Name:	**Date of Birth** (Required)	**Social Security #** (Required)			
Last Name:					

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Last Name:					

Full Name of Legal Dependent	Legal Dependent	Sex	Medical	Dental	Vision
First Name:	-	-	-	-	-
Middle Name:	**Date of Birth** (Required)	**Social Security #** (Required)			
Last Name:					

I hereby apply for (or request change in) the coverage(s) as indicated above for which I am eligible under contracts of group insurance issued to my employer. I understand that some coverage(s) require approval of my insurability before they become effective. I authorize payroll deductions for my share of the premiums. I understand that if I am off the payroll with rights to reinstatement and my employment is reinstated within one year, and my optional and dependent coverage(s) is in effect immediately prior to my layoff or leave of absence will be reinstated. My employer will deduct, from my wages, the necessary premiums to effect this reinstatement. This option can be rescinded at any time prior to the date of my reinstatement by sending written notice to my employer.

Signature: Date:

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