

EFFECTIVE DATE: 01 / 01 / 2025

PERSONAL INFORMATION:

SOCIAL SECURITY NUMBER:		PARTICIPANT'S NAME: FIRST		MI	LAST
ADDRESS: STREET			CITY:	STATE:	ZIP:
HOME PHONE: ()	WORK PHONE: ()	DATE OF BIRTH:		DATE OF HIRE:	SEX: ☐ F ☐ M
EMPLOYER: O'Fallon District 90		E-MAIL ADDRESS: ☐ By checking this box and providing my E-mail address above, I consent to receive Plan documents and all related Plan communications electronically. I understand that I am able to revoke this authorization by writing the Plan Administrator.			

Are you actively working for the employer listed above (as defined in your Insurance contract)? ☐ Yes ☐ No ☐ Full-time ☐ Part-time	HOURS WORKED/WEEK:
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BENEFIT ELECTIONS:

MEDICAL PLAN (3 Options - select below) Carrier: <u>BCBS IL</u> Plan Type <u>HRA, High Deductible, HSA - select below</u> Carrier Group # <u>P40148 (PPO) or P76927 (HSA)</u> ☐ Participant Only <u>Select Medical Plan</u> ☐ Participant + Spouse ☐ Option 1 (HRA) P40148 ☐ Participant + Children ☐ Option 2 (High Ded) P40148 Family ☐ Option 3 (HSA) P76927 ☐ Waive Coverage*	DENTAL PLAN (Low or High - select below) Carrier <u>Guardian</u> Plan Type <u>Low or High - select below</u> Carrier Group # <u>0483112</u> ☐ Participant Only <u>Select Dental Plan</u> ☐ Participant + 1 ☐ Option 1 - Low Plan Family ☐ Option 2 - High Plan ☐ Waive Coverage* ☐	VISION PLAN (VSP or Davis select below) Carrier <u>Guardian</u> Carrier Group # <u>0483112</u> ☐ Participant Only <u>Select Vision Network</u> ☐ Participant + 1 ☐ Option 1 - VSP ☐ Family ☐ Option 2 - Davis ☐ Waive Coverage* ☐
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FAMILY INFORMATION: (only required if covered on the plan)

Last,	Full First,	M.I.	Social Security Number	Birth Date	Sex	Disabled (Y/N)	Coverage Type: (circle all that apply)
Participant							<i>Med - Den - Vis - Vol Life</i>
SPOUSE							<i>Med - Den - Vis - Vol Life</i>
CHILD							<i>Med - Den - Vis - Vol Life</i>
CHILD							<i>Med - Den - Vis - Vol Life</i>
CHILD							<i>Med - Den - Vis - Vol Life</i>

OTHER HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare.

Do you or your dependents have "health" coverage with another insurer? ☐ No ☐ Yes if Yes: Effective Date: _____

Other Carrier name/policy # _____ Will this coverage be continued? ☐ Yes ☐ No if No: Effective Date: _____

Are you covered by Medicare? ☐ No ☐ Yes Effective Date: (Part A): ____/____/____ Effective Date (Part B): ____/____/____ Medicare # _____

Is your spouse or dependent(s) covered by Medicare? ☐ No ☐ Yes Effective Date: (Part A): ____/____/____ Effective Date (Part B): ____/____/____

Name of spouse or dependent(s) covered (if applicable): _____ Medicare # _____

***Waiver of Coverage: I certify that group coverage has been offered to me and I choose to waive coverage due to:**
☐ Spousal Coverage ☐ Individual Coverage ☐ Military Coverage ☐ COBRA ☐ Medicare as primary under TEFRA ☐ No Coverage

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. **Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**
Notice Regarding Special Enrollment Rights: If you are declining enrollment in the Medical component of the plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days of your other coverage ending. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

Participant AUTHORIZATION: I hereby request coverage for myself and my eligible dependents, and authorize my employer to deduct from my earnings the amount required to participate in the elected benefits. I understand that certain payroll deductions will be made on a pre-tax basis. I further understand that these benefits will remain in effect and cannot be changed or revoked unless the change is on account of and consistent with a Status Change or until an affirmative election is made during a subsequent open enrollment period. Dependents may include my spouse; unmarried children under 20 years of age; unmarried children under 26 years of age if they are full-time students at recognized institutions. Attainment of such age shall not terminate the coverage of a dependent unmarried child during the term of this agreement if he or she is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is mainly dependent upon the subscriber for support and maintenance. Stepchildren and legally adopted children, who are in my care are included. Enrolled dependents determined to be ineligible shall be terminated and charged for services rendered at the fee-for-service rate less any co-payments and premiums paid for said dependents. I have carefully read this enrollment form and agree to its terms. All of the information I have given on this application is true to the best of my knowledge. The information on this application will form the basis for the insurance applied for. I understand that the insurance is not in force until approved by the insurance carrier(s). THIS IS AN ENROLLMENT FORM NOT AN APPLICATION FOR INSURANCE.

PARTICIPANT SIGNATURE _____ **DATE** _____