



# Northern School District Trust

## Medical Enrollment Form

NSDT  
 c/o CESA #12  
 400 Lake Shore Dr. E  
 Ashland, WI 54806  
 Fax: 715-682-7244

Joanne Long- (715) 685-1833  
 Trisha Griffiths- (715) 685-1832

Employer	Employer District: _____	Group #: _____
	Insurance Effective Date: _____	
	First Day of Employment: _____	

Employee	Last Name	First	M.I.	Date of Birth	S.S. #
	_____				
	Address _____			Home Phone: _____	
	_____			Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
	City	State	Zip	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	

**Medical Plan Selected:**  Traditional (PPO)  HDHP/HAS  Single  Family  Other

**\* If enrolling in a Family Plan, please list your Spouse/Dependents**

Spouse/Dependents	First Name	M.I.	Last Name	Date of Birth	S.S. #	Relationship	Gender

\* If Dependents listed above do **NOT** reside at the Employee address, list the dependent(s) name and address on the Reverse side of this enrollment form.

\* If you, your spouse, or any of your dependents have any other Medical coverage you must complete a Coordination Of Benefits Form and send it with this application

Waive	I have decided not to apply for the coverage offered for: <input type="checkbox"/> Self <input type="checkbox"/> Dependents and I understand that this may affect applying for coverage at a later date.	
	_____ Signature	_____ Date

Accept	I enroll for the eligible benefits I indicated above and authorize deductions from my earnings if required.	
	_____ Signature	_____ Date