



**Northern School District Trust
2026 - 2027 Medical Enrollment Form
May 11th, 2026 – May 20th, 2028**

Northern School
District Trust
C/o CESA #12
400 Lake Shore Dr. E
Ashland, WI 54806
Fax: 715-682-7244

Section 1 – General Employee and Dependent Information

Employee Last Name	Employee First Name		
Employee Home Address	City	State	Zip Code
Employee Work Phone Number	Employee Home or Cell Phone Number (With Area Code)		
Employee DOB	Employee SSN		

☐ Please check this box indicating there are **no changes** to those dependents covered under the plans elected. If there are changes, please indicate the changes below.

For Dependent Additions or Changes Complete the Section Below

Last Name	First Name	MI	SSN (Required)	Date of Birth	Gender	Is this Dependent Considered a "Tax Dependent" for IRS Purposes?	Check Plans in Which to Enroll Each Dependent
Spouse ☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical
Child(ren) ☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical
☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical
☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical
☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical
☐ Add ☐ Delete						☐ Yes ☐ No	☐ Medical

If dependent/s listed above do not reside at the Employee address, list the dependent/s name and address below.

Address Line 1	Address Line 2 (Optional)	City	State	Zip Code
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Other Medical Coverage Information – On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including Medicare?

☐ Yes (continue completing this section) ☐ No (skip the rest of this section)

☐ a high deductible plan (HSA allowed) ☐ a lower deductible plan (HSA not allowed) ☐ a Medicare plan (HSA not allowed)

Covered Person's Name: _____ Carrier's Name: _____ Group Number: _____

SEE NEXT PAGE TO MAKE BENEFIT SELECTIONS

After you have completed the form above, save a copy with the information you entered. Share the completed form with Human Resources by May 20th, 2026.

Section 2 - Medical Plan Options – Anthem

To view a side by side comparison of both plans, please see your Benefit Guide.

Select Plan Option and Premium	Option 1 – Traditional PPO Plan \$2,000 Single / \$4,000 Family Deductible
	Monthly / Per Pay Period Premium
☐ Employee Only	\$98.78 /\$53.88
☐ Family	\$224.89 /\$122.67
☐ I WAIVE medical coverage for myself and my eligible dependents.	

Section 3 - Dental – Delta

To view in-depth plan details, please see your Benefit Guide

Select Option Below	Monthly / Per Pay Period Premium
☐ Employee	Admin/Teachers \$3.87/\$2.12 Support Staff \$2.95/\$1.61
☐ Family	Admin/Teachers \$11.85/\$6.47 Support Staff \$8.99/\$4.91
☐ I WAIVE Dental coverage for myself and my eligible dependents.	

Signature Required

I hereby certify that all the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved by the Northern School District Trust.

I, the undersigned, who currently participates in the benefit plans offered by the Northern School District Trust, agree to a salary reduction (pretax deduction) equal to my share of the premium for the insurance plans in which I am enrolled. See plan elections above. **NOTE: There may be occasions when additional premium deductions are withheld due to timing of start date, payroll period selected and effective date of coverage.** This salary reduction agreement is irrevocable until June 30, 2027, and will remain in effect from year-to-year unless a change is permitted by the applicable benefit plan(s) and/or cafeteria plan. Please reach out to your HR Department for specific details. This agreement will remain in effect notwithstanding changes in insurance plan coverage, premiums, or modifications of coverage during the plan year.

I acknowledge that I have been given the opportunity to enroll in the above group coverage offered by the Northern School District Trust and decline to enroll (as indicated above). I understand that by declining coverage, I may not have the opportunity to enroll myself or my dependents on the employer's plan until the next open enrollment period or a special enrollment event (e.g., marriage, birth/adoption of a child or a qualifying loss of other coverage).

Employee Signature:

Date: