



2027 OPEN ENROLLMENT BENEFIT CHANGE FORM

Effective Date: 1/1/2027

Return completed form by 4:00pm Friday, October 30th, 2026 to:

Human Resources Department
104 Fifth Ave. S.
South St. Paul, MN 55075
Fax: 651-457-9496

EMPLOYEE INFORMATION

Date of Qualifying Event (MM/DD/YYYY) 1/1/2027	Last Name	First Name	Middle Initial
Date of Birth (MM/DD/YYYY)	Social Security Number		Gender

TYPE OF CHANGE REQUEST (Select all that apply)

- | | |
|--|---|
| ☐ Add dependent | ☐ Change dental coverage |
| ☐ Remove dependent | ☐ Cancel all current benefit elections |
| ☐ Change medical coverage | |

MEDICAL INSURANCE CHANGE (Select ONE Medical Plan and ONE Coverage Tier)

Medical Plan	☐ No change ☐ \$500-\$35 Copay Plan ☐ \$1500-\$35 Copay Plan	☐ \$3500 HSA Plan ☐ Cancel Medical Coverage
Coverage Tier	☐ No change ☐ Employee Only	☐ Employee + One ☐ Family

DENTAL INSURANCE CHANGE (Select ONE)

Dental Plan	☐ No change ☐ Employee Only ☐ Family	☐ Cancel Dental Coverage
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FAMILY INFORMATION (List all dependents being added and/or removed)

Full Name	Gender	Birthdate (MM/DD/YYYY)	Relationship to Applicant	Social Security Number	Cancel/Enroll in: (M) or (D) or (Both)

FLEXIBLE SPENDING ACCOUNT(S) CHANGE(S)

If you would like to make adjustments or start contributions to your Health Care Spending Account or Dependent Care Spending Account, please fill out Medsurety's "Flexible Spending Account Enrollment Form."

****PLEASE CONTINUE TO OTHER SIDE.****

SUPPLEMENTAL LIFE INSURANCE CHANGE

Additional Employee Life may be purchased in increments of \$10,000, up to the plan maximum of \$500,000. Evidence of Insurability may be required for elections made outside of New Hire Enrollment.

- ☐ No change to Supplemental Life Coverage
- ☐ Elect supplemental life insurance to the amount of \$_____
- ☐ Waive supplemental life insurance

PRIMARY BENEFICIARY DESIGNATION CHANGE (For Basic Life/AD&D Insurance/Supplemental Life Insurance only)

If no changes to beneficiaries, leave blank. On the lines below, list the individual(s) who should receive proceeds in the event of your death. Total proceeds *MUST equal 100%*. Attach additional pages as necessary.

Full Name	Relationship to Applicant	Social Security Number	Percent Share of Proceeds
1.			
2.			
3.			

SECONDARY BENEFICIARY DESIGNATION CHANGE (For Basic Life/AD&D Insurance/Supplemental Life Insurance only)

If no changes to beneficiaries, leave blank. On the lines below, list the individual(s) who should receive proceeds ONLY IF ALL the individuals listed above are not living at the time of your death. Total proceeds *MUST equal 100%*. Attach additional pages as necessary.

Full Name	Relationship to Applicant	Social Security Number	Percent Share of Proceeds
1.			
2.			
3.			

ACKNOWLEDGEMENTS

I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am eligible. I authorize any physician, other health professionals, hospitals and other health care institutions, to provide the carrier's contracted physicians, consulting health professionals, utilization review organizations, and independent claim administrators with whom the carriers have contracted, information concerning health care advice, treatment or supplies, including those involving mental illness, provided me and/or my dependents, relating to coverage under these plans. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on the carriers by federal or state law. The carriers may provide South St. Paul Schools with any benefit calculation used in the payment of these claims for the purpose of reviewing the experience and operation of the policy or contract. My signature below affirms that all information and statements provided on the form are full, complete and true to the best of my knowledge.

Signature:

Date: