

## Medical Enrollment Form

SECTION 1 -- EMPLOYEE INFORMATION (Please complete in full and print clearly.)			
Employee Last Name	First	MI	Social Security #
Street Address			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip Code	Date of Birth / / Employee Number
Home Phone Number ( ) -	Reason: <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Increase in hours <input type="checkbox"/> Return from leave		Job Title: Effective Date:

SECTION 2 -- MEDICAL ENROLLMENT						
<b>MEDICAL COVERAGE</b>	<u>I elect coverage for:</u> <input type="checkbox"/> Single <input type="checkbox"/> Single + 1 <input type="checkbox"/> Family			<u>I elect the following plan type:</u> <input type="checkbox"/> Open Access 15 <input type="checkbox"/> Open Access 35 <input type="checkbox"/> Open Access Deductible plus VEBA		
Dependent Information: <i>(Please complete if you are enrolling dependents for coverage)</i>						
Last Name <i>(If Different From Above)</i>	First Name	MI	Relationship	Date of birth	Sex	Social Security #
Spouse:			Spouse			
Dependent(s):						

Do all of the dependent(s) listed above reside at the same address as the applicant?  yes  no  
 If NO, list dependent(s) name and address: \_\_\_\_\_

<b>WAIVER OF COVERAGE:</b>  <b>PT TEACHERS ONLY</b>	<b><u>PT Teacher working &lt;.8FTE:</u></b> <i>Can waive coverage pursuant to contract provisions</i>  <input type="checkbox"/> I wish to waive coverage in the ISD #279 health insurance plan
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SECTION 3 – Coordination of Benefits
<b>ADDITIONAL MEDICAL COVERAGE INFORMATION:</b> Do you or any family members included on this enrollment form have other medical coverage in addition to this plan? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes:</b> Is other coverage with HealthPartners? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no: Complete the Coordination of Benefits form and return with enrollment form to Human Resources. <a href="http://www.district279.org/departments/humanresources/employeebenefits/documents/2007-08/042908_COB_39527">www.district279.org/departments/humanresources/employeebenefits/documents/2007-08/042908_COB_39527</a></b>

SECTION 4 -- SIGNATURE (Employee must sign and date, even if declining coverage.)								
I authorize the required deduction (if any) from my wages. I understand that medical, dental and FSA deductions are pre-tax and I acknowledge that my Social Security Benefits may be slightly reduced as a result of my election. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Benefits Election Form, I authorize HealthPartners to share information about me with any medical provider, sponsoring employer, or other entity, where such information is reasonably necessary for administration. <u>I understand that my election is irrevocable for the plan year, unless I experience a qualifying event &amp; notify the plan in writing within 30 days of the date of the QE.</u>								
I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN DENIAL OF CLAIM(S), CANCELLATION OF OR RECISSION OF COVERAGE.								
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-top: 1px solid black; border-bottom: 1px solid black;"></td> <td style="width: 50%; border-top: 1px solid black; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">EMPLOYEE SIGNATURE</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">DATE SIGNED</td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"></td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">PLAN ADMINISTRATOR SIGNATURE</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;">DATE SIGNED</td> </tr> </table>			EMPLOYEE SIGNATURE	DATE SIGNED			PLAN ADMINISTRATOR SIGNATURE	DATE SIGNED
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