Miami Trace Local Schools

A. EMPLOYER INFORMATION:

Location	Hire Date	Date Waiting Period Began	Effective Date	Network	Basic Life/AD&D	Supp. Life	LTD
	/ /20	/ /20	/ /20		$ -	$ -	$ -

Application is for: ☐New Enrollment ☐ Enrollment Change (if change, check below)

☐Add Spouse ☐Add Child(ren) ☐Drop Employee ☐Drop Spouse ☐Drop Child(ren) ☐Change Name ☐Change Address

B. EMPLOYEE INFORMATION:

Last Name	First Name / MI	Sex	Date of Birth	Social Security #	Phone #
		☐Male ☐Female	Mo/Day/Yr / /	- -	
Street Address	**City**	**State**	**Zip Code**	**E-mail Address**	

C. DEPENDENT INFORMATION: (List all dependents to be covered under your chosen plan)

Last Name	First Name / MI	M/F	Date of Birth	Social Security #	Relationship	Add/Drop
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		

D. PLAN OPTIONS: (Please select your plan(s)

Medical Plan(s)
Choose One
☐PPO
☐H S A
☐Minimum Value
☐Waive

Enrollment
☐Enrollee Only
☐Enrollee + Spouse
☐Enrollee + Child(ren)
☐Family

Optional Voluntary Life / AD&D Through Dearborn National

Employee
☐Elect Life
☐Waive Life
☐Elect AD&D
☐Waive AD&D

Spouse
☐Elect
☐Waive

Child(ren)
☐Elect
☐Waive

Contact Rob Herron 740-335-1867

E. OTHER COVERAGE INFORMATION:

Does your spouse or any dependent have other health insurance? ☐Yes ☐No If yes, provide:

Coverage Type ☐Medical ☐Dental ☐Vision

Name(s) of Covered Person(s) ______________________ Effective Date ____/____/____

Employer ______________________
Name Address Phone#

Claims Payor ______________________
Name Address Phone#

F. LIFE/AD&D BENEFICIARY INFORMATION (School Paid Life Insurance):

Your Death Benefits are to be paid to First Beneficiary(ies): | If First Beneficiary(ies) is not living at your death, benefits are to be paid to Secondary Beneficiary(ies)

Name	Relationship	% of Benefits	Name	Relationship	% of Benefits

ACCEPTANCE:

I hereby apply for group coverage for which I am or may become eligible as elected above. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I understand that I must meet the eligibility requirements of the Plan and that the completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

I elect to have my contribution to the cost of such coverage deducted from my pay on a pre-tax basis. I understand that the cost to me for coverage will be deducted from my gross earnings prior to calculation of certain taxes to be withheld each pay period. I also understand that I may not make any changes in my pre-tax election until the next pre-tax open enrollment period. However, I understand that an election change is permitted due to significant cost or coverage changes to me or a change in my family status as outlined in the Summary Plan Description.

Employee Signature ______________________ Date ______________

DECLINATION:

I hereby decline medical coverage under my employer's medical plan for myself ☐ and/or my dependents ☐ I understand I may not be able to enroll until the next Open Enrollment Period or within 30 days of an event that qualifies as a "Special Enrollment" event.

Employee Signature ______________________ Date ______________

PRE-TAX CONTRIBUTION DECLINATION:

*Check and sign this box **only** if you want your contributions to be subject to payroll taxes*

☐ I <u>do not</u> wish to have my share of the cost, for the coverages I have elected to be deducted from my pay on a pre-tax basis.

Employee Signature ______________________ Date ______________