HOOSIER SCHOOL BENEFIT TRUST - EMPLOYEE ENROLLMENT FORM

EMPLOYER'S Statement (*to be completed by employer*)
School Corporation: MSD of Decatur Township Group Number: 218107 Effective Date_____

No. of Hours Worked Per Week_____ Occupation _____Date of Hire/Re-Hire_____

Employer Authorization_____Date_____
ENROLLMENT CODE: [ ] New Hire [ ]New Enrollment for COBRA Qualifying Event
[ ] COBRA Coverage Exhausted[ ] Death of Spouse
[ ] Divorce/Legal Separation[ ] Employment Terminated
[ ] Employer/Group Plan Contribution Ceased [ ]Other
If Other, explain_____

COMPLETE THIS SECTION ONLY IF WAIVING COVERAGE- To Enroll, Skip to Section B

Section A – Waiver of Coverage (*This section must be completed for employee and / or any eligible dependent not enrolling the group health plan when initially eligible due to coverage elsewhere)*

Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage

I certify that I have been given an opportunity to apply for group health coverage through the Trust and I am declining as indicated above. I understand that I will be only be able to enroll in the future if I or my dependent(s) experience a HIPAA special enrollment event. I also understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents as long as I apply for coverage within 31 days of the event. It is important to note that only the employee, spouse and newly acquired dependent(s) receive special enrollment rights under this provision. Other dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the employee's acquisition of a new dependent.

_____ **Date**_____
(Employee Signature) (Only if Waiving Coverage)

Section B – Coverages Requested:

MEDICAL: Plan 1/ Plan 2 _____ **Plan 3** _____ **Plan 4 (HSA)** _____ **Plan 5 (HSA)** _____

Employee Only _____ Employee and Spouse _____ Employee and Child(ren) _____ Family _____

DENTAL: Core Plan _____ **Enhanced Plan** _____

Employee Only _____ Employee and Spouse _____ Employee and Child(ren) _____ Family _____

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years? ☐Yes ☐No

REMINDER: ***To avoid any pre-existing condition provision as required by this Group Health Plan, you will need to provide a Certificate of Creditable Coverage from your prior health carrier***

Section C – Employee / Application Information

First Name	Last Name	MI	Date of Birth	Sex	Social Security #	
				☐ M ☐ F		☐ Single ☐ Married ☐ Divorced

Home Address: Phone: E-Mail:	City:	State:	Zip:

If you are enrolling your spouse or dependent child(ren) the following documents must accompany your application:
For your spouse: A copy of your marriage certificate; ***AND*** documentation dated within the last 60 days establishing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list your name and your spouse's name, the date, and your mailing address. **For your child(ren):** A copy of the child's birth certificate, naming you as the child's parent, or appropriate adoption decree naming you as the adoptive parent; ***AND*** if applicable, a copy of a divorce decree granting full or joint custody (names of all parties must be included); ***OR*** if applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order where you are required to provide healthcare (names of all parties must be included). **For stepchild(ren):** A copy of the child's birth certificate, naming your spouse as the child's parent; ***AND*** A copy of your marriage certificate as proof of the dependent's relationship to the member; ***AND*** Documentation dated within the last 60 days establishing current relationship status such as a joint household bill, joint bank/credit account statement, joint mortgage/lease statement, or insurance policies. (The document must list your name and your spouse's name, the date, and your mailing address to validate member and spouse, not the child). **For Disabled Child(ren):** Same as above for other children AND a copy of the front page of your most recent filed federal tax return to confirm you claimed this dependent.

Section D – Spouse Information

First Name	Last Name	MI	Date of Birth	Sex ☐ M ☐ F	Phone Number: Social Security #:

Is your spouse employed?
[ ] Yes [ ] No If Yes, please provide name of employer:_____
Does your spouse have medical coverage through his/her employer?
[ ] Yes [ ] No

Section E – Family Information All Information is Required (*attach separate sheet if necessary)*

First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: ☐ Son ☐ Daughter ☐ Other	Social Security #

Section F – Other Health Coverage

List yourself and any other family members to be enrolled in this plan who will be covered by other health coverage on this plan's effective date:

Provide name & address of insurance carrier:_____

Policyholder Name: _____Relationship to Employee:_____

Group/Account/Policy ID Number:_____ Effective Date_____ Termination Date:_____

If you and/or your dependent(s) are enrolled in Medicare or Medicaid, please complete the following:

Enrollee Name:	Medicare/Medicaid ID #	Medicare Part A Effective Date:	Medicare Part B Effective Date:

Reason for Medicare eligibility/entitlement:

By signature, I declare that the information provided is complete and correct. By electing coverage under this Plan, I also agree to have the applicable premium deductions made. I accept that I am responsible to notify my employer of any change that would make me or any dependent ineligible for benefits under the Trust group health plan.

_____ **Date:** _____
(Employee/Applicant Signature)

Your coverage is issued by a multiple employee welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.