

HOOSIER SCHOOL BENEFIT TRUST - EMPLOYEE ENROLLMENT FORM



EMPLOYER'S Statement (to be completed by employer)

School Corporation: Decatur 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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Home Address:			City:	State:	Zip:	
Phone: E-Mail:						

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 <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number: Social Security #:
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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: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	Social Security #
First Name:	Last Name:	MI	Date of Birth:	Relationship to EE: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> 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:
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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.

 (Employee/Applicant Signature) Date: _____

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.