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|  | **Egyptian Area Schools Employee Benefit Trust** |
| **ENROLLMENT FORM** | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION  **RETURN THIS COMPLETED FORM TO YOUR EMPLOYER**  (Employer Representative – Unsigned or incomplete forms will be returned and may delay enrollment) | | | | | | | | | | | | | | | | | | | | | **(For Employer Use Only)- Employers retain a copy for your records.**  **Confirmation No.** | | | | | | | | | | | | | | | | | | |
| Employer Name | | | | | | | | | | | | | | | | | | | | | Group Number | | | | | | | Certified Staff  Yes  No | | | | | | | | Effective Date         /     / | | | |
| Enrollment Event: | | Open Enrollment-Applies to medical plan only  New Hire  Qualifying Change in Family Status Reason | | | | | | | | | Annual Enrollment-Applies to dental plan only  Late Enrollment | | | | | | | | | | | | | | | | | Employee Status | | | | | | | | Date of Hire       /     / | | | |
| Active  Retiree | | | | COBRA  Other | | | |
| Will Employee be Medicare Eligible at Age 65?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Certified by (Authorized Representative) | | | | | | | | | | | | | | | | | | | | Date       /     / | | | | | | | | Employer Telephone | | | | | | | | | | | |
| Employers please indicate which Health Plan options your district offers: | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Enter information at** [**www.meritain.com**](http://www.meritain.com) | | | | | | | | | | | |
| Plan A | Plan B | | | | Plan C | | | | HDHP  Plan E1 | | | | | | | | All Plans | | | | | | | | | | |
| **EMPLOYEE INFORMATION: EMPLOYEE MUST COMPLETE THIS SECTION** (Incomplete forms will be returned and may delay enrollment) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee Name Last First MI | | | | | | | | | | | | | Sex  M  F | | | | Date of Birth       /     / | | | | | | | | | Marital Status | | | | | | | Social Security Number | | | | | | |
| Single | | | Widowed | | | |
| Married | | | Divorced | | | |
| Civil Union | | | | | | |
| Employee Home Address Street/Apt. City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone:  Business Phone: | | | | | | Email Address | | | | | | | | | | | | Occupation:  Average Hours Worked per Week: | | | | | | | | | | | | | | | | | Earnings $ | | | | |
| Hourly  Weekly | | Monthly  Annually | | |
| **EMPLOYEES: You must check one box in each section below.** | | | | | | | | | | | | | | | | | | | | | | | | | **EMPLOYEES: Check all boxes that apply:** | | | | | | | | | | | | | | |
| Medical Plan Options | | | | **Voluntary**  **Teladoc** | | | | | **Voluntary Dental**  **High**  **Low** | | | | **Voluntary Vision** | | | | | | | | | | | **Basic Life –**  Basic Life is automatic when enrolling in Health Plan | | | | | | | | | | | | | | | |
| **Plan A**  **Plan B**  **Plan C**  **HDHP**  **Plan E1** | | | | Basic Life Amount:  Decline coverage | | | | | | | | | | | | | | | |
| **Optional Life –**  When applying for more than guaranteed issueamounts an Evidence of Insurability form must be completed. | | | | | | | | | | | | | | | |
| Employee Only  Employee + Spouse  Employee + Child or Children  Family  Decline Coverage NOTE: Includes Teladoc, Basic Life Insurance and Prescription Coverage. | | | | Employee Only  Decline Coverage | | | | | Employee Only  Employee + 1 Dependent  Employee + 2 or more deps  Decline Coverage | | | | Employee Only  Employee + 1 Dependent  Employee + 2 or more deps  Decline Coverage | | | | | | | | | | | Optional Employee Life Amount:  Note: Evidence of Insurability Form required for amounts over $100,000  Optional Spouse Life Amount:  Note: Limited to 50% of Employee Life – Evidence of Insurability required for amounts over $37,500  Optional Dependent Life  $5,000 or  $10,000  Note: Covers all eligible children  Decline Coverage | | | | | | | | | | | | | | | |
| **NOTE:**  Teladoc is included in Medical Plan. | | | | |  | | | |  | | | | | | | | | | |
| List Full Name of Your Eligible Dependents | | | | Relation To Employee  1-Spouse  2-Child  3-Stepchild  4-Other | | | Sex  M or F | | | Date  of  Birth | | | | | Dependent  Social Security Number  (Required when enrolling  dependents.) | | | | | | | | | | You must mark the coverage chosen or decline coverage  for each dependent listed. | | | | | | | | | | | | | | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
|  | | | |  | | | M  F | | | /     / | | | | |  | | | | | | | | | | Medical | | | | | | Dental | | | Vision | | | | Decline | |
| OTHER INSURANCE COVERAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you or any of your dependents covered by another group, medical, dental, or vision plan? | | | | | | | | | | | | | Yes | | | | No | | If yes, type(s) of coverage:  Medical  Vision  Dental | | | | | | | | | | | | | | | | | | | | |
| Name of individual with other coverage:       Effective Date of other coverage      /     /  Name of insurance carrier or TPA:       Group No.  Address:       Phone:  Name of employer providing coverage:  Is other coverage Medicare or Medicaid?  Yes  No Medicare/Medicaid Effective Date of coverage      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (9-05) EGT-ENR REVISED 6/15 EMPLOYER RETAIN ORIGINAL FOR YOUR FILE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BASIC LIFE – Beneficiary Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Beneficiary's Last Name First MI | | | | | | | | | | | | | | Relationship of Beneficiary | | | | | | | | DOB       /     / | | | | | | | | | Primary Beneficiary’s Social Security Number | | | | | | | | |
| Street Address City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contingent Beneficiary's Last Name First MI | | | | | | | | | | | | | | Relationship of Beneficiary | | | | | | | | DOB       /     / | | | | | | | | | Contingent Beneficiary’s Social Security Number | | | | | | | | |
| Street Address City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OPTIONAL LIFE – Beneficiary Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Beneficiary's Last Name First MI | | | | | | | | | | | | | | Relationship of Beneficiary | | | | | | | | DOB       /     / | | | | | | | | | Primary Beneficiary’s Social Security Number | | | | | | | | |
| Street Address City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contingent Beneficiary's Last Name First MI | | | | | | | | | | | | | | Relationship of Beneficiary | | | | | | | | DOB       /     / | | | | | | | | | Contingent Beneficiary’s Social Security Number | | | | | | | | |
| Street Address City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Note:** A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE) | | | | | | | | | | | | | | | | | | | | | | | | | | | **Dearborn National** | | | | | | | | | | | | |
| This coverage has been offered to me and after careful consideration of the benefits, I have decided to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"I APPLY FOR THE BASIC GROUP LIFE BENEFITS** indicated above and, if my application is approved by Dearborn National, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex." | | | | | | | | | | | | | | | | **"I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS** indicated above and, if my application is approved by Dearborn National, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex." | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program.**  I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense." | | | | | | | | | | | | | | | | **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program.**  I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense." | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense." | | | | | | | | | | | | | | | | | | | | | | | |
| NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.  The insurance requested on this enrollment form will not be effective until approved by the Home Office of Dearborn National, and the initial premium is paid to Dearborn National. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUEST FOR COVERAGE (MEDICAL) | | | | | | | | | | | | | | | | | | | | | | | | | | | **Administered by Meritain Health** | | | | | | | | | | | | |
| This coverage has been offered to me and after careful consideration of the benefits, I have decided to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by Egyptian Area Schools Employee Benefit Trust, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex." | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program.**  I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply." | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUEST FOR COVERAGE (VOLUNTARY TELADOC) | | | | | | | | | | | | | | | | | | | | | | | | | | | **Administered by Meritain Health** | | | | | | | | | | | | |
| This coverage has been offered to me and after careful consideration of the benefits, I have decided to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"I APPLY FOR THE GROUP BENEFITS** indicated above and, I authorize deductions from my pay for any required contributions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the Teladoc Program.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUEST FOR COVERAGE (VOLUNTARY DENTAL) | | | | | | | | | | | | | | | | | | | | | | | | | | | **Ameritas** | | | | | | | | | | | | |
| **Select Coverage.** Confirm the options available to you by reviewing your benefit plan description or checking with your employer. Note: Except for COBRA continuance, dependent coverage may be elected only if employee coverage is elected. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This coverage has been offered to me and after careful consideration of the benefits, I have decided to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by Ameritas, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex." | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program.**  I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply." | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REQUEST FOR COVERAGE (VOLUNTARY VISION) | | | | | | | | | | | | | | | | | | | | | | | | | | | **VSP, Administered by Ameritas** | | | | | | | | | | | | |
| This coverage has been offered to me and after careful consideration of the benefits, I have decided to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by Ameritas, I authorize deductions from my pay for any required contributions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program.**" | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please read, sign, and date the following Authorization & Acknowledgement   * I have read and understand the information provided in the summary of benefits and other enrollment materials. * On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law. * Are you declining any coverage due to coverage in another plan?  Yes  No   If yes, is the other coverage COBRA?  Yes  No  Other (Please Explain)  To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee’s Signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | |
| (9-05) EGT-ENR REVISED 6/15 EMPLOYER RETAIN ORIGINAL FOR YOUR FILE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |