EMPLOYEE ENROLLMENT FORM

Employer's Statement (to be completed by employer)

Group Number(s) **Clay Community Schools Health 00110995, Subgroup 2101; Life 3772; LTD 6587**

Annual Salary $______________ Life Class________ Life Amount $______________ Effective Date________________

# of Hours worked per Week__________ Occupation____________________ Date of Hire/Re-Hire______________

Employer Signature ____ Date______________________

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

Name of Person Declining	Social Security	Date of Birth	Coverage is Provided By
			☐Spouse ☐Parent ☐No Coverage
			☐Spouse ☐Parent ☐No Coverage
			☐Spouse ☐Parent ☐No Coverage
			☐Spouse ☐Parent ☐No Coverage
			☐Spouse ☐Parent ☐No Coverage
			☐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 only be able to enroll in the future if I or my dependent(s) experience a qualifying event as defined by HIPAA guidelines. 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.

____ **Date**______________________________

Employee Signature

Section B – Coverages Requested:

☐Employee Only ☐ Medical ☐ Life/AD&D (Amt $____________________) ☐ LTD

☐Dependent(s) ☐ Medical

Health Plan Choice: ☐ Plan 6-HSA $3,350

Life Insurance Beneficiary: Last Name________________________ First Name ____________________MI________

Date of Birth________________________ Relationship________________________

Contingent Beneficiary: Last Name________________________ First Name ____________________MI________

Date of Birth________________________ Relationship________________________

List additional names on separate page if necessary

Section C – Employee/Application Information

First Name	MI	Last Name	Date of Birth	Sex ☐M ☐F
Social Security #	☐Single ☐Married ☐Divorced	Street		
Phone		City	State	Zip
Work Phone		Email Address		

Section D – Required information for dependents to be covered by plan (Attach separate sheet if necessary)

First Name	MI	Last Name	Date of Birth	Social Security #	Relationship	
					Spouse	☐ Male ☐ Female
					☐ Son ☐ Other ☐ Daughter	☐ Male ☐ Female
					☐ Son ☐ Other ☐ Daughter	☐ Male ☐ Female
					☐ Son ☐ Other ☐ Daughter	☐ Male ☐ Female
					☐ Son ☐ Other ☐ Daughter	☐ Male ☐ Female
					☐ Son ☐ Other ☐ Daughter	☐ Male ☐ Female

Section E – 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:

Name of Insured:	Their Birth Date:	Relationship to Employee:

Name and Address of Other Insurance Company

Group/Account/Policy ID Number:	Who is covered by this other plan?	Effective Date of other plan:

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

Enrollees Name	Medicare/Medicaid ID#	Medicare Part A Effective Date	Medicare Part B Effective Date

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 employer 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.