# Enrollment Application

*Return this form to Employee Benefits Department*

Health Insurance / Prescription Drug / Dental

## Employee Information

❐ **Active Employee (Position ____________________)** ❐ **Early Retiree**

**Date of Hire: ________________________________** **Date of Retirement: ____________________**

| LAST NAME OF APPLICANT | FIRST NAME / MI | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

| ADDRESS NUMBER AND STREET | CITY | STATE | ZIP | HOME PHONE ( ) | CELL PHONE ( ) |
|---|---|---|---|---|---|
| | | | | | |

| BIRTHDATE MONTH DAY YEAR / / | SEX ❐ MALE ❐ FEMALE | MARITAL STATUS ❐ Single ❐ Legally Separated ❐ Married ❐ Divorced | EMAIL ADDRESS |
|---|---|---|---|

REASON FOR ENROLLMENT: ❐ Open Enrollment ❐ New Hire ❐ Part-Time to Full-Time ❐ Loss of other coverage ❐ COBRA ❐ Status Change

| Is the employee covered by another employer group insurance plan? ❐ YES ❐ NO<br>*(If Yes, complete following information and Type of Coverage at right)*<br>Employer Name and Address ________________________________<br>Insurance Company Name and Address/Phone | TYPE OF COVERAGE – SECONDARY INSURANCE<br>❐ Medical ❐ Family ❐ Single Effective Date ________<br>❐ Dental ❐ Family ❐Single Effective Date ________<br>❐ Vision ❐ Family ❐Single Effective Date ________<br>❐ Drug ❐ Family ❐Single Effective Date ________ |
|---|---|

## Health / Prescription Drug Election Information – *Choose Plan and Coverage OR check Waive Coverage box below.*

| *Choose one:* ❐ DEAN HEALTH PLAN ❐ MERCYCARE | *Choose one:* ❐ HMO ❐ POS ❐ PPO *(Out of area residents **ONLY**)* | *Choose one:* ❐ Single ❐ Employee / Spouse ❐ Family ❐ Employee / Child(ren) |
|---|---|---|

❐ I WISH TO **WAIVE** HEALTH AND PRESCRIPTION DRUG COVERAGE AT THIS TIME. I UNDERSTAND I MAY APPLY FOR HEALTH AND PRESCRIPTION DRUG INSURANCE DURING ANNUAL OPEN ENROLLMENT OR UPON A QUALIFIED LIFE EVENT.

## Dental Election Information – Active Employees Only

*Choose one. You may **only** enroll in Dental coverage if you **also** enroll in Health/ Prescription Drug coverage.*

❐ YES, I WISH TO **ENROLL** IN DENTAL COVERAGE AT THIS TIME. MY DENTAL COVERAGE WILL ALIGN WITH THE COVERAGE THAT I ELECTED FOR HEALTH COVERAGE - SINGLE OR FAMILY (Employee/Spouse, Employee Child(ren), Family).

❐ I WISH TO **WAIVE** DENTAL COVERAGE AT THIS TIME. I UNDERSTAND I MAY APPLY FOR DENTAL INSURANCE DURING ANNUAL OPEN ENROLLMENT OR UPON A QUALIFIED LIFE EVENT IN CONJUNCTION WITH HEALTH/PRESCRIPTION DRUG INSURANCE.

## Spouse Information (Fill out only if you will be covering your spouse on the plan)

| NAME (Last, First, MI) | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| Is this dependent **eligible to be covered** by another group insurance plan? ❐ YES ❐ NO<br>Is this dependent **currently covered** by another group insurance plan? ❐ YES ❐ NO<br>(If Yes, complete following information)<br>Employer Name and Address ________________________________<br>Insurance Company Name and Address/Phone ____________________<br>My spouse also works for the School District of Janesville. ❐ YES ❐ NO | TYPE OF COVERAGE<br>❐ Medical ❐ Family ❐ Single Effective Date ________<br>❐ Dental ❐ Family ❐Single Effective Date ________<br>❐ Vision ❐ Family ❐Single Effective Date ________<br>❐ Drug ❐ Family ❐Single Effective Date ________ |
|---|---|

| Is this dependent eligible for Medicare Coverage? ❐ Yes ❐ No | REASON ❐ Over 65 ❐ Disabled | PART A (Hosp.) EFFECTIVE DATE | PART B (Med.) EFFECTIVE DATE | MEDICARE CARD # |
|---|---|---|---|---|

## Other Dependent Information

| NAME (Last, First, MI) | SOCIAL SECURITY NUMBER | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|
| | | | |
| Is this dependent covered by another group insurance plan other than through his/her Employer or their Spouse's Employer? ❐ Yes ❐ No | TYPE OF COVERAGE ❐ Medical ❐ Dental ❐ Vision ❐ Drug | | IS THIS DEPENDENT DISABLED? ❐ Yes ❐ No |

| NAME (Last, First, MI) | SOCIAL SECURITY NUMBER | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|
| | | | |
| Is this dependent covered by another group insurance plan other than through his/her Employer or their Spouse's Employer? ❐ Yes ❐ No | TYPE OF COVERAGE ❐ Medical ❐ Dental ❐ Vision ❐ Drug | | IS THIS DEPENDENT DISABLED? ❐ Yes ❐ No |

| NAME (Last, First, MI) | SOCIAL SECURITY NUMBER | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|
| | | | |
| Is this dependent covered by another group insurance plan other than through his/her Employer or their Spouse's Employer? ❐ Yes ❐ No | TYPE OF COVERAGE ❐ Medical ❐ Dental ❐ Vision ❐ Drug | | IS THIS DEPENDENT DISABLED? ❐ Yes ❐ No |

**I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS PRINTED ON THE BACK OF THIS PAGE.**

Signature: ________________________________________ Date Completed: ____________________________

***Sign your name here – Do Not Type or Print*** ***This form is valid only if signed and dated.***

White Copy: Benefits Yellow Copy: Insurance Provider Pink Copy: Payroll Gold Copy: Employee

Date Received in HR: ____________ By:___________ *(initials)*

**SCHOOL DISTRICT OF JANESVILLE HEALTH/PRESCRIPTION DRUG/DENTAL BENEFITS**

**TERMS AND CONDITIONS**

I CERTIFY THAT THE DEPENDENTS LISTED ARE MY DEPENDENTS AND THAT THEY QUALIFY AS DEPENDENTS AS DEFINED BY THE GROUP PLAN OF MY EMPLOYER. I AGREE TO NOTIFY THE PLAN ADMINISTRATOR WHEN THERE IS A CHANGE IN ANY DEPENDENT'S STATUS.

**I UNDERSTAND THAT AS AN EMPLOYEE, I AM REQUIRED TO PROVIDE THE PROPER DOCUMENTATION, INCLUDING BIRTH CERTIFICATES, MARRIAGE CERTIFICATES OR DIVORCE DECREES TO CONFIRM MY DEPENDENTS PROPER COVERAGE UNDER THESE PLANS AS REQUESTED BY MY EMPLOYER.**

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT COULD BE GUILTY OF INSURANCE FRAUD. ANY MISSTATEMENTS MAY BE USED AS A BASIS FOR RECISION OF ELIGIBILITY.

I REQUEST THE AMOUNT(S) AND FORM(S) OF COVERAGE FOR WHICH I AM ELIGIBLE UNDER THE PLANS OF MY EMPLOYER AND I AUTHORIZE SAME TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS INCLUDING ANY APPLICABLE SURCHARGE. DUE TO THE REQUIRED CONTRIBUTION BEING PRE-TAX, THIS ELECTION WILL REMAIN IN PLACE UNTIL THE NEXT OPEN ENROLLMENT OR QUALIFYING/LIFE EVENT THAT WOULD REQUIRE A CHANGE TO THIS ELECTION.