Enrollment Application/Change/Cancellation Request

Employees complete sections A, C and F. If adding dependents complete section B

☐ Enroll ☐ Cancel ☐ Change | ☐ Address Change ☐ Name Change Date of Change___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #
Roxana School District	709833	

Plan Variation
Medical X
Vision ______
Dental ______
Life ______

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) ____________________
☐ COBRA/State Continuation start date _______ stop date________
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached student/dependent max age
☐ Other (describe)____________________

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _______ ☐ COBRA/State Cont.

Signature Kim Sherako Date ________
Employer Position Payroll Officer Phone Number 618-254-7543

A. Employee Information

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth	Sex	Physician* (First & Last Name)	
/ /	☐ M ☐ F		

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________

C. Product Selection Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical
Employee	☐
Spouse	☐
Dependents	☐

Choice Plus (POS) ☐
HSA Choice Plus ☐

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / MI Social Security Number	Sex	Relationship**	Birthdate	Full Time Student***
□ Enroll □ Cancel □ Change		M F	Spouse		
Race – Check all that apply (Optional)**** □ American Indian/Alaska Native □ Asian □ Black/African-American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Other–Please specify ______					
□ Enroll □ Cancel □ Change		M F	Dependent		□ Yes □ No
Race – Check all that apply (Optional)**** □ American Indian/Alaska Native □ Asian □ Black/African-American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Other–Please specify ______					
□ Enroll □ Cancel □ Change		M F	Dependent		□ Yes □ No
Race – Check all that apply (Optional)**** □ American Indian/Alaska Native □ Asian □ Black/African-American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Other–Please specify ______					
□ Enroll □ Cancel □ Change		M F	Dependent		□ Yes □ No
Race – Check all that apply (Optional)**** □ American Indian/Alaska Native □ Asian □ Black/African-American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Other–Please specify ______					
□ Enroll □ Cancel □ Change		M F	Dependent		□ Yes □ No
Race – Check all that apply (Optional)**** □ American Indian/Alaska Native □ Asian □ Black/African-American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White □ Other–Please specify ______					

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken □ English □ Spanish □ Other ______