NORTH CENTRAL INDIANA SCHOOL INSURANCE TRUST

EMPLOYEE ENROLLMENT FORM

EMPLOYER'S Statement (*to be completed by employer*)

School Corporation: M069- Union Co College Corner Joint School District **Group Number:** W10833 Effective date______________

Hours Worked Per Week__________ Occupation _________________________ Date of Hire/Re-Hire_________________

Employer Authorization____Date____________________________________

ENROLLMENT CODE:
- ☐ New Hire
- ☐ COBRA Coverage Exhausted
- ☐ Divorce/Legal Separation
- ☐ Other (explain:____________________________________)
- ☐ New Enrollment for COBRA Qualifying Event
- ☐ Death of Spouse
- ☐ Employment Terminated

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 in the group health plan when initially eligible due to coverage elsewhere)*

Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage
Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage
Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage
Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage
Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage
Name:	Coverage waiving: ☐ Medical ☐ Dental ☐ Vision	Coverage provided by: ☐ Spouse ☐ Parent ☐ No Coverage

By signature below, I acknowledge that I have been given an opportunity to enroll myself and my eligible dependents in the Trust group health plan and have elected to waive coverage as noted above. I also understand that I will not be permitted to enroll myself or my dependents in the plan until the next designated Open Enrollment Period, or 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. NOTE: 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 – Medical Coverage Selection Information

Circle One	Active M069 Retiree MR69 COBRA MC69	Active M070 Retiree MR70 COBRA MC70	Active M071 Retiree MR71 COBRA MC71	Active M072 Retiree MR72 COBRA MC72
Employee	☐ **PPO 1**	☐ **PPO 2**	☐ **HDHP 1**	☐ **HDHP 2**
EE/Child(ren)	☐ **PPO 1**	☐ **PPO 2**	☐ **HDHP 1**	☐ **HDHP 2**
EE/Spouse	☐ **PPO 1**	☐ **PPO 2**	☐ **HDHP 1**	☐ **HDHP 2**
Family	☐ **PPO 1**	☐ **PPO 2**	☐ **HDHP 1**	☐ **HDHP 2**

Section C - Employee/Application Information (all fields must be completed)

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy	☐ Single ☐ Married ☐ Divorced

Home Address (include PO Box if applicable)	City	State	Zip

Home Phone ( )	Work Phone ( )

Email Address	Document Preference ☐ ONLINE ☐ PAPER

Section D – Spouse Information

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy

Section E – Family Information – (all fields must be completed for each covered dependent)					
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy

Section F – Other Health Coverage

List yourself and any 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 of Coverage:_______________________

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:

Section G – Prior Health Coverage

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years?

☐ Yes (*complete information below)*

☐ No

List yourself and any other family members who have had prior coverage:	Name of Insurance Carrier: Group/Account/Policy ID Number: Coverage Effective Date: Coverage Termination Date: Reason for Termination: ☐ Divorce/Legal Separation ☐ Death of Spouse ☐ COBRA Coverage Exhausted ☐ Termination of Employment ☐ Employer Premium Contribution Ceased ☐ Other - Please explain__________________ ____

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. All enrollments must be submitted within *31* days of the qualifying event. All required documentation must accompany this form in order to process the enrollment.

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 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.

NCISIT Office Use Only

Spouse: Marriage Certificate _________ Current Tax/Bill Doc _________ Cert of Creditable Coverage _________

Child: Birth Certificate ___________ Court Order/Adoption Decree _________