Instructions for Completing Enrollment Form
Health, Dental, and Vision insurance
FY20-21

Questions: Call Kathy at 319-342-2674 or e-mail at k_krug@union.k12.ia.us

This form will replace any enrollment form you currently have on file with the district. If you are completing the form to make changes, you will need to list all coverage you want, not just the changes.

Section A: (Information should be for Union CSD employee carrying the coverage)

- On the first line check the appropriate box (New Hire, Change, or Open Enrollment).
- On second line:
    - If you marked "Change", one of the boxes on the second line showing the type of event causing the change needs to be marked and the Event Date needs to be completed.
    - For "New Hire" or "Open Enrollment", "Event Date" should be as follows:

➢ For annual "Open Enrollment", the Event Date should be July 1st of current year,
➢ For "New Hire" at the beginning of the school year, enter Sept 1st of current year,
➢ For "New Hire" during the year, coverage will begin at the beginning of the month following the board's approval of hiring, (I can help you with the date).

- The remaining information in Section A is the employee's information.

➢ **Be sure all areas in the section are completed, including the employee's gender, marital status, Medicaid enrolled, and social security disabled.**

Section B: Be sure to review the health, dental and vision coverage prior to completing so you know which selections you want to make.

Medical:
- Check the boxes next to the coverages you want to select (Self, Spouse, and/or Children).
- For Plan Type: Enter the plan you selected – Classic 500, Select 1500, or HDHP2500 NE

Dental:
- Check the boxes next to the coverage you want to select (Self, Spouse, and/or Children).
- On the Plan Type line, list the Dental Program you are selecting, as follows:
  For the Comprehensive Plan, write "COMP"
  For the Preventive Plan, write "PREV"
  For the Catastrophic Plan, write "CATA"

  Note: IF you selected the two-person coverage, write the name of the additional person to the left of the Plan Type you select.

Vision:
- Check the boxes next to the coverage you want to select (Self, Spouse, and/or Children).
- On the Plan Type line, list the Vision Program you are selecting, as follows:
  For Employee Only coverage, write "Empl"
  For Employee + One Dependent coverage, write "Empl+1"
  For Employee + Family coverage, write "Family"

  Note: IF you selected the two-person coverage, write the name of the additional person to the left of the Plan Type you select.

H.S.A: We do not use this company for the H.S.A. Please leave blank.

(over)

Section C: Do NOT complete. I will complete this section

Section D: Do NOT complete. We do not have beneficiary coverage on any insurance through this company.

Section E:

- List spouse/dependents to be covered by any of the insurance coverage in Section B
- Be sure to complete all columns for spouse and/or each dependent to be covered

Section F:

- If you or any dependent listed in Section E has additional health insurance coverage which will be in effect at the same time as the coverage listed above, list the requested information in this section. If needed, attach additional page with information.

Section G:

- There are only six waiver boxes in this section that need to be reviewed; Employee Health, Dental, and Vision, and Dependent Health, Dental, and Vision.
- If you did not select all coverage offered in Section B for yourself, check the Employee box(es) in Section G which correspond with the coverage you are not taking.
  - For example: If you selected single health coverage for yourself, but did not elect dental or vision coverage, check the boxes to waive the Employee Dental and Employee Vision coverage here.
- If you did not select all coverage offered in Section B for your spouse/dependents, check the Dependent box(es) in Section G which correspond with the coverage you are not taking.
  - For example: If you selected health coverage for you and your dependents, but did not select vision coverage for any of your dependents, check the box to waive the Dependent Vision coverage here.

  Note: If you selected one of the Employee +1 plans in Section B, you will leave the corresponding waiver boxes in Section G blank for both you and your dependents.

- Employee needs to sign and date this section
- A witness also needs to sign and date this section

Section H:

- Employee should sign and date

Send completed form to District Office. Thank you!

Mercer Administration, A Service of Seabury & Smith, Inc. co. # _____ ee. # _____

A. Application Type

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee (indicate event & date below) ☐ Change (indicate event & date below) ☐ Open Enrollment

Event Requiring Contract Change: ☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Other_____ Event Date _____

SSN	Name (Last)	(First)	(MI)

Birth Date	Address (Street)	(Apt/Ste #)

Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Common Law	(City)	(State)	(Zip)	(Phone Number)

Medicare Enrolled? ☐ Yes ☐ No | Soc. Sec. Disabled? ☐ Yes ☐ No | Medicare ID (HIC) No. ☐ Part A ☐ Part B ☐ Part D Eff. Date:

B. Coverage Election – Please indicate the coverage you are choosing

Medical (if applicable):	☐ Self	☐ Spouse	☐ Child(ren)	Plan Type_____
Dental (if applicable):	☐ Self	☐ Spouse	☐ Child(ren)	Plan Type_____
Vision (if applicable):	☐ Self	☐ Spouse	☐ Child(ren)	Plan Type_____
HSA (if applicable):	☐ Self	☐ Spouse	☐ Child(ren)	Plan Type_____

☐ Life ☐ AD & D ☐ STD ☐ LTD

C. Employer – Please complete shaded section for applicant

Company Name	Applicant Occupation		
Union Community School District			
Company Location	**Class**	**Employer Signature**	**Date**
La Porte City, IA		Business Manager	

Hire Date	Eff. Date	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA	Salary $	☐ Monthly ☐ Annually
		Please indicate plan if multiple plans are available: ☐ Health _____ ☐ Dental _____ ☐ Vision _____		

☐ Employee Life	☐ Employee AD&D	☐ Employee Opt. Life	☐ Dependent Life	☐ Spouse Opt. Life	☐ Employee STD	☐ Employee LTD
$	$	$	$	$	$	$

D. Beneficiary Information

	Birth Date	SSN	Relationship	%
Primary Beneficiary				
Contingent Beneficiary				

E. Dependents Enrolled (First, MI, Last)

	Birth Date	Social Security Number	Does dependent reside at home?	Gender	Full Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse				☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ Yes ☐ No	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ Yes ☐ No	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ Yes ☐ No	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ Yes ☐ No	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

F. Other Coverage Information If you, your spouse or anyone named on this application will keep other hospital and/or medical coverage in addition to this coverage, please complete the following:

Name (First, MI, Last)	Employer (if applicable)		
Insurance Company/ HMO Name and Address	Policy No.	Contract Type: ☐ Single -Medical ☐ Family -Medical ☐ 2 person-Medical	Eff. Date:

G. Employee Waiver of Coverage

I, the undersigned, hereby certify that I have been given an opportunity to enroll in the group plan sponsored by my employer. After careful consideration, I have elected not to participate in the following coverage(s). I further understand that, should I decide to participate at a future date, I may have to furnish satisfactory evidence of insurability for myself and, if applicable, any eligible dependents. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, 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, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- ☐ Employee Health
- ☐ Employee Dental
- ☐ Employee Vision
- ☐ Employee Life
- ☐ Employee AD&D
- ☐ Employee Weekly Indemnity (STD)
- ☐ Employee Long Term Disability (LTD)
- ☐ Employee Optional Life
- ☐ Spouse Optional Life
- ☐ Dependent Health
- ☐ Dependent Dental
- ☐ Dependent Vision
- ☐ Dependent Life
- ☐ Other_____

Employee Signature_____

Date_____

Witness Signature _____

Date_____

H. Employee Signature (Required for all available lines of coverage)

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the coverage elected on this form. I hereby represent that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my annual earnings and I further represent that I am not presently disabled and I am performing all the duties of my occupation. (This statement applies to any disability coverage).

Signature_____ Date_____

OFFICE USE ONLY

UPDATE STAMP HERE

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