HEALTH & DENTAL BENEFIT PLAN ENROLLMENT

OFFICE USE ONLY:

☐ ADMIN ☐ ESP ☐ OTHER STAFF ☐ RETIRED ☐TEACHER

☐RESIGNED ☐ REDUCED IN FORCE

TERMINATION DATE:

EFFECTIVE DATE:

☐ OPEN ENROLLMENT ☐ INITIAL ENROLLMENT (NEW EMPLOYEE /QUALIFYING EVENT)

☐ ADD SPOUSE/DEPENDENT (QUALIFYING EVENT) ☐ CHANGE OF STATUS

☐ CHANGE OF DEMOGRAPHIC INFORMATION

NAME OF MEMBER(S) TERMINATING: _____

☐ DIVORCED ☐ DECEASED ☐ INVOLUNTARY ☐ OVER MAXIMUM AGE ☐ PER EMPLOYEE REQUEST ☐TRANSFER TO INDIVIDUAL COVERAGE ☐ VOLUNTARY

I. ENROLLEE INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	PHONE NUMBER

STREET ADDRESS AND APT NUMBER	CITY & STATE	ZIP CODE	SEX
			☐ MALE ☐ FEMALE

HIRE DATE	DISABLED	MEDICARE NUMBER	MEDICARE EFFECTIVE DATE (IF APPLICABLE)
	☐ YES ☐ NO		

MARITAL STATUS AND DATE

☐ SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DOMESTIC PARTNERSHIP ☐ SAME SEX LEGAL SPOUSE ☐ OTHER_____ ☐ DATE OF MARRIAGE _____

EMPLOYMENT STATUS:

☐ ACTIVE ☐ ACTIVE (PART TIME) ☐ RETIRED ☐ DEPENDENT SURVIVOR ☐ COBRA

MEDICAL COVERAGE : ☐ INDIVIDUAL ☐ INDIVIDUAL+SPOUSE ☐ INDIVIDUAL + CHILD(REN) ☐ FAMILY

DENTAL COVERAGE : ☐ INDIVIDUAL ☐ INDIVIDUAL+SPOUSE ☐ INDIVIDUAL + CHILD(REN) ☐ FAMILY

II. SPOUSE / DOMESTIC PARTNER INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE

MEDICARE NUMBER	EFFECTIVE DATE (IF APPLICABLE)	DISABLED	DATE OF DISABILITY
		☐ YES ☐ NO	

III. DEPENDENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX
					☐ MALE ☐ FEMALE

IV. ADDITIONAL INFORMATION

ARE ANY OF YOUR DEPENDENT(S) DISABLED?	LIST NAME(S) OF DISABLED DEPENDENT(S)	MEDICARE NUMBER(S) & EFFECTIVE DATE(S) (IF APPLICABLE)

DO YOU OR YOUR SPOUSE/DEPENDENT(S) HAVE OTHER HEALTH OR DENTAL COVERAGE? ☐ HEALTH ☐ DENTAL	LIST NAME OF ENROLLEE AND MEMBERS ENROLLED IN THE PLAN	NAME OF CARRIER & POLICY NUMBER

V. AUTHORIZATION TO ENROLL IN PLAN OR WAIVE COVERAGE (check enroll or waive and approve with signature)

☐ ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN ☐ WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE

☐ ENROLL IN THE PPSTA BENEFIT TRUST DENTAL PLAN ☐ WAIVE PPSTA BENEFIT TRUST DENTAL COVERAGE

EMPLOYEE SIGNATURE	***DATE***
PRINT NAME	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each violation