

HEALTH & DENTAL BENEFIT PLAN ENROLLMENT



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| OFFICE USE ONLY: <input type="checkbox"/> ADMIN <input type="checkbox"/> ESP <input type="checkbox"/> OTHER STAFF <input type="checkbox"/> RETIRED <input type="checkbox"/> TEACHER <input type="checkbox"/> RESIGNED <input type="checkbox"/> REDUCED IN FORCE TERMINATION DATE: <input type="checkbox"/> DIVORCED <input type="checkbox"/> DECEASED <input type="checkbox"/> INVOLUNTARY <input type="checkbox"/> OVER MAXIMUM AGE <input type="checkbox"/> PER EMPLOYEE REQUEST <input type="checkbox"/> TRANSFER TO INDIVIDUAL COVERAGE <input type="checkbox"/> VOLUNTARY | EFFECTIVE DATE: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> INITIAL ENROLLMENT (NEW EMPLOYEE /QUALIFYING EVENT) <input type="checkbox"/> ADD SPOUSE/DEPENDENT (QUALIFYING EVENT) <input type="checkbox"/> CHANGE OF STATUS <input type="checkbox"/> CHANGE OF DEMOGRAPHIC INFORMATION NAME OF MEMBER(S) TERMINATING: _____ |
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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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| HIRE DATE | DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO | MEDICARE NUMBER | | MEDICARE EFFECTIVE DATE (IF APPLICABLE) | |
| MARITAL STATUS AND DATE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DOMESTIC PARTNERSHIP <input type="checkbox"/> SAME SEX LEGAL SPOUSE <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DATE OF MARRIAGE _____ | | | | | |
| EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> ACTIVE (PART TIME) <input type="checkbox"/> RETIRED <input type="checkbox"/> DEPENDENT SURVIVOR <input type="checkbox"/> COBRA | | | MEDICAL COVERAGE : <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIVIDUAL+SPOUSE <input type="checkbox"/> INDIVIDUAL + CHILD(REN) <input type="checkbox"/> FAMILY | | |
| | | | DENTAL COVERAGE : <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIVIDUAL+SPOUSE <input type="checkbox"/> INDIVIDUAL + CHILD(REN) <input type="checkbox"/> FAMILY | | |

II. SPOUSE / DOMESTIC PARTNER INFORMATION

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|-----------------|--------------------------------|--|-----------------------------------|--------------------|--|
| LAST NAME | FIRST NAME | INITIAL | SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| MEDICARE NUMBER | EFFECTIVE DATE (IF APPLICABLE) | DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO | | DATE OF DISABILITY | |

III. DEPENDENT INFORMATION

| | | | | | |
|-----------|------------|---------|-----------------------------------|---------------|--|
| LAST NAME | FIRST NAME | INITIAL | SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| LAST NAME | FIRST NAME | INITIAL | SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| LAST NAME | FIRST NAME | INITIAL | SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| LAST NAME | FIRST NAME | INITIAL | SOCIAL SECURITY NUMBER (REQUIRED) | DATE OF BIRTH | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |

IV. ADDITIONAL INFORMATION

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| 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) <input type="checkbox"/> HEALTH | LIST NAME OF ENROLLEE AND MEMBERS ENROLLED IN THE PLAN | |
| HAVE OTHER HEALTH OR DENTAL COVERAGE? <input type="checkbox"/> DENTAL | NAME OF CARRIER & POLICY NUMBER | |

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

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| <input type="checkbox"/> ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN <input type="checkbox"/> WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE <input type="checkbox"/> ENROLL IN THE PPSTA BENEFIT TRUST DENTAL PLAN <input type="checkbox"/> 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