SOUTH CENTRAL INDIANA SCHOOL TRUST
EMPLOYEE ENROLLMENT FORM

The South Central Indiana School Trust is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for this multiple employer welfare arrangement.

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Birth Date	Social Security No.	Telephone #
					( )

Home Address	City	State	ZIP

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

COVERAGE INFORMATION – MEDICAL & DENTAL

	Anthem Blue Access				Dental Blue 300
	PPO Plan $1,500 Single $3,000 Family	PPO Plan $5,000 Single $10,000 Family	HDHP/HSA $2,000 Single $4,000 Family	HDHP/HSA 3,000 Single $6,000 Family	Dental
Employee	☐	☐	☐	☐	☐
EE/Spouse	☐	☐	☐	☐	
EE/Child(ren)	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐

I would like to waive coverage under the Trust ☐ Medical ☐ Dental

If you are declining coverage, are you covered under another health plan? ☐ Yes ☐ No

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty days after marriage, birth, adoption, or placement for adoption.

If you decline coverage when first eligible for any other reason, you may not be able to enroll in coverage until the annual open enrollment period unless you experience a special qualifying event as outlined in the plan.

ELIGIBILITY INFORMATION

Eligibility Concerning You or Your Spouse:

Yes	No	
		Are you or your spouse engaged in any other occupational activity other than your employment with the School? If yes, please explain.

Eligibility for Dependent Children of the Employee: My dependent children, named below meet the following definition:

Yes	No	
		They are natural children, legally adopted children, step-children and children for whom you or your spouse is legal guardian.

DEPENDENT INFORMATION – COMPLETE ONLY IF DEPENDENTS ARE TO HAVE COVERAGE

Spouse's Name Last First MI	Date of Birth	Sex	Spouse's Social Security #	I'm divorced or legally separated from my spouse. If this event happened within the past year, please provide the date:	
Child's Name Last First MI	Date of Birth	Sex	Child's Social Security # (MUST HAVE)	Relationship: Natural Child / Step Child / Legally Adopted / Other Please Specify	Under Age 26: Yes / No
1				☐ ☐ ☐ ☐	☐ ☐
2				☐ ☐ ☐ ☐	☐ ☐
3				☐ ☐ ☐ ☐	☐ ☐
4				☐ ☐ ☐ ☐	☐ ☐

(If you need additional space, please use a separate sheet of paper.)

TO ASSIST US IN THE COORDINATION OF BENEFITS AND TIMELY CLAIMS PAYMENT, PLEASE COMPLETE THE FOLLOWING:

If your spouse is employed outside the home, does your spouse have coverage under the employer's health Plan? ☐ Yes ☐ No

If yes, please provide:

1. Person Carrying Coverage:
2. Social Security #:
3. Effective Date of Coverage:
4. Carrier Name and Telephone Number:

Type of Coverage: Medical: Dental: Both:

Are any children insured by the School Trust Plan also covered by any health insurance through your spouse or their employer sponsored plan? ☐ Yes ☐ No

If yes, please provide the following: Type of Coverage: ☐ Medical ☐ Dental ☐ Both

Last First MI	
Name:	Date of birth:
Name:	Date of birth:
Name:	Date of birth:
Name:	Date of birth:
Name:	Date of birth:

Please provide the following information:

1. Person Carrying Coverage:
2. Social Security #:
3. Effective Date of Coverage:
4. Carrier Name and Telephone Number:

AUTHORIZATIONS AND WAIVER

☐ I authorize deductions from earnings as may be required for contributions to plan cost.

I realize I must notify the school administration department of any change in my dependent's eligibility status as defined above. I also realize that failure to do so may waive my dependent's right to continue coverage as allowed under COBRA law.

I declare that the information I have furnished is true, complete and correct.

Signature of employee _____ Date Signed _____

NOTICE TO LATE ENROLLEES

If you do not enroll within 31 days after becoming eligible, you will be unable to enroll until the annual open enrollment period unless you experience a special qualifying event as outlined in the plan.

EMPLOYER SECTION (MUST BE COMPLETED)

School Corporation Name: Edinburgh Community School Corporation

Benefit Class	Date of Full-Time Employment	Occupation	Hours Worked
I			

☐ NEW EMPLOYEE ☐ SPECIAL ENROLLEE ☐ DEPENDENT SPECIAL ENROLLEE ☐ REHIRE
☐ WAIVE ALL COVERAGE ☐ ANNUAL OPEN ENROLLMENT ELECTION

☐ RETURN TO WORK FROM: Layoff _____ Leave _____ Strike _____ Disability _____

Special Enrollment will be available if the Employee completes the enrollment process within 30 days following the loss of other coverage.
Dependent Special Enrollment will be available if the Employee completes the enrollment process within 30 days following the qualifying event.

ADMINISTRATIVE USE ONLY

Location Number **Effective Date** Coverage

Comments:

Revised 08-1-17

Signature of plan administrator _____ Date Signed _____