MEBC –MERCER COUNTY

EMPLOYEE BENEFIT PROGRAM ENROLLMENT FORM PLAN YEAR 2021

YOUR INFORMATION

COMPLETE ALL INFORMATION IN THIS SECTION

EMPLOYEE'S FIRST NAME	LAST NAME	MI	Employee ID #	SEX	BIRTHDATE	SOCIAL SECURITY #	EFFECTIVE DATE OF COVERAGE

DEPARTMENT	JOB TITLE	MARITAL STATUS	PREFERRED EMAIL ADDRESS

HOME ADDRESS	CITY / STATE	ZIP CODE	HOME PHONE NUMBER

REASON FOR ENROLLMENT/CHANGE/TERMINATION

REASON FOR APPLICATION

- ◯ NEW ENROLLMENT
- ◯ ADD/CANCEL DEPENDENT
- ◯ OTHER: _____

STATUS/CHANGE EVENT

- ◯ MARRIAGE
- ◯ BIRTH
- ◯ ADOPTION
- ◯ LEGAL GUARDIANSHIP
- ◯ DIVORCE
- ◯ DEATH
- ◯ LOSS OF COVERAGE (REASON) _____
- ◯ OTHER: _____

SELECT YOUR COVERAGE

WAIVE COVERAGE (OPT-OUT)

YOU MAY ELECT OPT-OUT OF INSURANCE BENEFITS. INSURANCE REGULATIONS REQUIRE THAT ALL EMPLOYEES SELECTING THE INSURANCE OPT-OUT ACKNOWLEDGE THEY ARE WAIVING COVERAGE ANNUALLY AND PROVIDE CURRENT PROOF OF OTHER INSURANCE COVERAGE.

YOUR ELECTION TO OPT-OUT IS REQUIRED ANNUALLY AND FAILURE TO RENOTIFY THE PLAN EACH YEAR WILL RESULT IN THE FORFEITURE OF ANY OPT-OUT COMPENSATION. TO BE ELIGIBLE, YOU MUST ACKNOWLEDGE BELOW AND RETURN THIS SIGNED FORM ALONG WITH PROOF OF OTHER COVERAGE TO THE TREASURER'S OFFICE NO LATER THAN THE END OF OPEN-ENROLLMENT FOR THE UPCOMING SCHOOL YEAR. CONSULT YOUR UNION AGREEMENT FOR FURTHER DETAILS.

I HEREBY ACKNOWLEDGE THAT I AM WAIVING ALL MEDICAL, PRESCRIPTION AND DENTAL BENEFITS FOR THE 2021 PLAN YEAR AND WILL NOT BE ABLE TO CHANGE THIS ELECTION WITHOUT A QUALIFIED CHANGE OF STATUS OR UNTIL THE NEXT OPEN ENROLLMENT. I UNDERSTAND THAT THE COUNTY MUST BE NOTIFIFED WITHIN 31 DAYS OF ANY QUALIFIED EVENT.

YOU MUST SUBMIT PROOF OF OTHER COVERAGE AND ACKNOWLEDGE THE ABOVE INFORMATION BY SIGNING HERE -> _____

ENROLL IN COVERAGE

SELECT YOUR COVERAGE AND BENEFIT OPTIONS

IF ENROLLING IN COVERAGE, SELECT THE LEVEL OF COVERAGE BELOW. FAMILY RATE APPLIES TO SINGLE+SPOUSE, SINGLE+CHILD(ren) AND FULL FAMILY ENROLLEES.

MEDICAL/DENTAL	VISION
◯ SINGLE	◯ SINGLE
◯ FAMILY	◯ FAMILY

PARTICIPANT ENROLLMENT INFORMATION

COMPLETE INFORMATION BELOW FOR ANY DEPENDENTS YOU ARE INSURING

PLEASE BE SURE TO REVIEW YOUR PLAN'S DESCRIPTION OF ELIGIBLE DEPENDENTS. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME AND WILL RESULT IN IMMEDIATE RECISSION OF COVERAGE AND LEGAL ACTION.

SP=SPOUSE CH=CHILD SCH=STEP CHILD MEMBER TYPE	FIRST NAME	LAST NAME	MI	GENDER	SOCIAL SECURITY #	DATE OF BIRTH	IS THIS DEPENDENT CURRENTLY WORKING FULLTIME?	IF EMPLOYED, DOES THEIR EMPLOYER OFFER HEALTHCARE?	IF THEY OFFER HEALTHCARE, IS THIS DEPENDENT ENROLLED?	SELECT TO ENROLL MEDICAL	SELECT TO ENROLL VISION

OTHER COVERAGE

COMPLETE THIS SECTION IF YOU OR YOUR DEPENDENTS MAINTAIN OTHER EMPLOYER SPONSORED, INDIVIDUAL OR MEDICARE AS OTHER HEALTH COVERAGE

ON THE DAY YOUR COVERAGE BEGINS, WILL ANY FAMILY MEMBERS YOU ARE ENROLLING BE COVERED UNDER ANY HEALTH COVERAGE? ◯ **NO** ◯ **YES** **IF SO, PROVIDE DETAILS BELOW:**

NAME OF PARTICIPANT	NAME OF CARRIER	POLICY/SUBSCRIBER #	EFFECTIVE DATE

LIFE INSURANCE INFO

COMPLETE INFORMATION BELOW FOR YOUR DISTRICT PAID, BASE LIFE INSURANCE BENEFIT

PRIMARY BENEFICIARY NAME(s) - MUST ADD UP TO 100%	RELATIONSHIP	% BENEFIT	BIRTH DATE	ADDRESS

OPTIONAL CONTINGENT/SECONDARY BENEFICIARY NAME(s)	RELATIONSHIP	% BENEFIT	BIRTH DATE	ADDRESS

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by the Plan; (b) to be eligible for coverage, I must be an active eligible participant as defined by the policy(ies); (c) to be eligible for life and or disability income insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my life and/or disability coverage will begin on the day I return to work; (d) if coverage is issued, it will be based on full reliance on the information contained in this Application.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy or electronic reproduction of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that my dependents and myself are hereby eligible for coverage after review of the Plan's eligibility parameters. All information that I have provided is true and complete to the best of my knowledge.

Furthermore, I understand that if no coverage has been elected or I have selected a waiver, I hereby refuse the Plan offered by my employer and recognize that my future enrollment may be subject to certain restrictions as defined by the Plan. By enrolling, I authorize payroll deductions that are required for the benefits that I elect. I understand that my elections are irrevocable unless I have a Qualified Status Change. In addition, I understand that the benefits for which I have enrolled may not be immediately available or available to me based on eligibility exclusions, limitations or waiting periods and final coverage requires certification by human resources before is shall be activated.

_____ **EMPLOYEE SIGNATURE**

_____ **DATE**