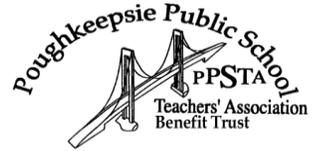


# HEALTH & DENTAL BENEFIT PLAN ENROLLMENT



**OFFICE USE ONLY:**

- ADMIN  
  ESP  
  OTHER STAFF  
  RETIRED  
  TEACHER  
 RESIGNED  
  REDUCED IN FORCE

**EMPLOYMENT STATUS:**

- ACTIVE  
  ACTIVE (PART TIME)  
  RETIRED  
 DEPENDENT SURVIVOR  
  COBRA

EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_      HIRE DATE: \_\_\_/\_\_\_/\_\_\_

**EVENT TYPE:**

- OPEN ENROLLMENT  
  INITIAL ENROLLMENT  
 NEW ADD | QUALIFYING EVENT  
 CHANGE OF STATUS     
  CHANGE OF DEMOGRAPHIC INFORMATION

TERMINATION DATE: \_\_\_/\_\_\_/\_\_\_      NAME OF MEMBER(S) TERMINATING: \_\_\_\_\_

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

**1. 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
MARITAL STATUS & DATE OF STATUS: ___/___/___					
<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 _____					

**2. SPOUSE / DOMESTIC PARTNER INFORMATION**

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
-----------	------------	---------	-----------------------------------	---------------	------------------	---

**3. DEPENDENT INFORMATION**

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? <input type="checkbox"/> Yes <input type="checkbox"/> No

**4. OTHER INSURANCE**

**Do you or you other family members have other health or dental insurance coverage?**    Yes\*    No

\* Carrier Name: \_\_\_\_\_ Name(s) of family members with other insurance: \_\_\_\_\_ Medical/Dental/Both?: \_\_\_\_\_

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

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

<b>[MEDICAL COVERAGE]</b>	<input type="checkbox"/> ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN <input type="checkbox"/> WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIVIDUAL+SPOUSE <input type="checkbox"/> INDIVIDUAL + CHILD(REN) <input type="checkbox"/> FAMILY ----- • ENROLLEE MEDICARE PRIMARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Employee Signature</i>
<b>[DENTAL COVERAGE]</b>	<input type="checkbox"/> ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN <input type="checkbox"/> WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIVIDUAL+SPOUSE <input type="checkbox"/> INDIVIDUAL + CHILD(REN) <input type="checkbox"/> FAMILY	<i>Date</i>