



Egyptian Area Schools Employee Benefit Trust

ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION (Employer Representative – Unsigned or incomplete forms will be returned and may delay enrollment)

(For Employer Use Only)- Employers retain a copy for your records.
Confirmation No. _____

Employer Name	Group Number	Department Number	Certified Staff <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date / /
Enrollment Event: <input type="checkbox"/> Open Enrollment- Applies to medical plan only <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Change in Family Status Reason _____	<input type="checkbox"/> Annual Enrollment- Applies to dental plan only <input type="checkbox"/> Late Enrollment	Employee Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other	Date of Hire / /	

Will Employee be Medicare Eligible at Age 65? Yes No

Certified by (Authorized Representative) _____ Date / / Employer Telephone () - _____

Employers please indicate which Health Plan options your district offers:
 Platinum Gold Silver Bronze All Plans

Enter information at www.meritain.com or
Mail to: MERITAIN HEALTH
300 CORPORATE PARKWAY
AMHERST, NEW YORK 14226

EMPLOYEE INFORMATION: COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)
Submit a copy of Certificate of Creditable Coverage with this form. Please check if no prior coverage.

Employee Name Last First MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Employee ID No.
Employee Home Address Street/Apt. City State Zip + four County	Home Phone () - _____		Business Phone () - _____	
Mailing Address if Different From Home Address	Occupation: _____	Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually		
	Average Hours Worked per Week: _____			

EMPLOYEES: You must check one box in each section below. **EMPLOYEES: Check all boxes that apply:**

Medical Plan Includes Rx Coverage <input type="checkbox"/> Platinum <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Bronze	Voluntary Dental Plan <input type="checkbox"/> High <input type="checkbox"/> Low	Vision	Basic Life (Basic Life is automatic when enrolling in Health Plan) <input type="checkbox"/> Basic Life <input type="checkbox"/> Decline coverage
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Deps <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Deps <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Optional Employee Life Volume _____ * Amounts over \$75,000 require completion of Evidence of Insurability Form <input type="checkbox"/> Optional Spouse Life Volume _____ * Limited to 50% of Emp Life – Amounts over \$25,000 require completion of Evidence of Insurability Form <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 * Covers all eligible children <input type="checkbox"/> Decline Coverage

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent ID Number (Required when enrolling dependents for coverage.)	Full-Time Student? (Y or N)	You must mark the coverage chosen or decline coverage for each dependent listed.
1.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
2.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
3.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
4.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
5.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
6.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, dental, or vision plan? Yes No
If yes, type(s) of coverage: Medical Dental Vision

Name of individual with other coverage: _____

Name of insurance carrier or TPA: _____ Group No. _____

Address: _____ Phone: _____

Name of employer providing coverage: _____

Is other coverage Medicare or Medicaid? Yes No

BASIC LIFE – Beneficiary Information						
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's ID No.	
Street Address		City		State	Zip	
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.	
Street Address		City		State	Zip	
OPTIONAL LIFE – Beneficiary Information						
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's ID No.	
Street Address		City		State	Zip	
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.	
Street Address		City		State	Zip	
Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.						
REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE)				Lincoln Financial Group P.O. Box 2616, Omaha NE 68103-2616 (800) 423-2765 fax: (877) 573-6177		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE BASIC GROUP LIFE BENEFITS indicated above and, if my application is approved by Lincoln Financial Group, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."			<input type="checkbox"/> "I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS indicated above and, if my application is approved by Lincoln Financial Group, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."			
<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."			<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."			
			<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense."			
NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY. The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln Financial Group, and the initial premium is paid to Lincoln Financial Group. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.						
REQUEST FOR COVERAGE (HEALTH PLAN)				Administered by Meritain Health		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by Egyptian Area Schools Employee Benefit Trust, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."						
<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program. I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."						
REQUEST FOR COVERAGE (VOLUNTARY DENTAL)				Delta Dental of Illinois Group Number 20204		
Select Coverage. Confirm the options available to you by reviewing your benefit plan description or checking with your employer. Note: Except for COBRA continuance, dependent coverage may be elected only if employee coverage is elected.						
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by Delta Dental of Illinois, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."						
<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program. I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."						
REQUEST FOR COVERAGE (VOLUNTARY VISION)				Administered by UniView		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by UniView, I authorize deductions from my pay for any required contributions.						
<input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program."						

Please read, sign, and date the following Authorization & Acknowledgement	
<ul style="list-style-type: none"> • I have read and understand the information provided in the summary of benefits and other enrollment materials. • On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law. • Are you declining any coverage due to coverage in another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the other coverage COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Please Explain) _____ 	
To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.	
Employee's Signature	Date: