OPEN ENROLLMENT BENEFIT ELECTION FORM

CLERKS: Please complete Section 1, Section 3 (Plan Type and Details), and Section 4 (indicate whether or not the group offers dental and/or vision).

EMPLOYEES: Please complete Section 2, Section 3 (mark your plan selection for Medical Benefits), and Section 5 (add or drop coverage for you and/or your dependents). Please sign and date Section 6 and submit to your District Clerk.

1 CLERKS ONLY — **Benefit Period:** ☐ **July** ☐ **September**

Group Name:	**Billing Group Number:**

DO NOT complete this form if you are NOT making any changes to your medical, dental and/or vision benefits. This form is ONLY to be used during the Open Enrollment period to make plan changes. Submit completed form directly to your School District Clerk upon completion.

2 EMPLOYEE ONLY

First Name:	**MI:**	**Last Name:**	**Last 4 of SSN:**

Current Plan:

3 MEDICAL BENEFITS

Employee Mark Selection	**Clerks Select Plans Offered by Group**	**Employee Mark Selection**	**Clerks Select Plans Offered by Group**
☐	**No Medical Benefits Plan changes**		
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details
☐	Select Plan Type and Plan Details	☐	Select Plan Type and Plan Details

4 DENTAL AND VISION BENEFITS

CLERKS ONLY: Does this group offer Dental? ☐ **Yes** ☐ **No** **Does this group offer Vision?** ☐ **Yes** ☐ **No**

5 EMPLOYEE ONLY — **MEMBER INFORMATION**

If you are adding or dropping coverage for yourself or your dependents, please list the information below.

First Name MI Last Name	Gender	Social Security #	Date of Birth	Relationship	Medical		Dental		Vision	
					Add	**Drop**	**Add**	**Drop**	**Add**	**Drop**
		- -			☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐

IF DROPPING COVERAGE: I understand that dropping medical coverage completely may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document. I acknowledge that I am also dropping the Basic Life Insurance and Long Term Disability (LTD) benefit provided by the plan, unless I am covered by MUST as a dependent under another policy provided by the same employer. (If covered under another medical coverage complete the Beneficiary section of this application.)

6 **I approve the plan changes as indicated above.**

_____ _____

SIGNATURE **DATE**

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: _____ Q/A INIT_____