Group Online Open Enrollment Form

You have chosen online Open Enrollment for your employees. This form is used to designate your preferences for this process, and will allow your employees to see their employer contributions. Please complete all sections of this form and return it with your renewal and life insurance worksheets by the renewal date deadline. Should your contributions be unknown at the time of renewal, please complete sections I and II, and return. MUST will designate contributions at $0 in Bswift, and your employees will be unable to see them; however, this will have no impact on Open Enrollment. Once contributions are known, please complete section III, and return to MUST, as this information is needed for ACA reporting. If your group is making no plan changes, your online enrollment will be set up in “Passive” mode. This means that employees who do not complete the online open enrollment process will be re-enrolled in their same benefit selections from the current plan year.

SECTION I — GENERAL INFORMATION

Group Name: ____________________

Contact Name: ____________________

Billing Address: ____________________

City: ____________ **State:** ____ **ZIP:** ________

Phone Number: ____________________

Fax Number: ____________________

Contact Email: ____________________

MUST Representative: ____________________

Agent Name: ____________________

Agent Employer: ____________________

Agent Phone Number: ____________________

Agent Address: ____________________

City: ____________ **State:** ____ **ZIP:** ________

Agent Email: ____________________

SECTION II — OPEN ENROLLMENT

Open Enrollment Dates:
From: ________ **To:** ________

Preferred Method of Employee Notification:
☐ **Email** ☐ **Memo**
**Employee email list required for email notifications*

Email Open Enrollment Reminder Options
☐ **Weekly**
☐ **Bi-Weekly** ☐ **Other:** ________

SECTION III — EMPLOYER CONTRIBUTIONS

Enter your Group’s Benefit Classes (e.g., certified, classified, administrators, etc.) then select one of the New Hire Rule options.
For additional Classifications, please attach an additional sheet.

Benefit Classification: ____________________

How much does your district contribute to this Classification?

Benefit Classification: ____________________

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Benefit Classification: ____________________

How much does your district contribute to this Classification?

Benefit Classification: ____________________

How much does your district contribute to this Classification?

Dental and Vision: Please enter the amount that is contributed, if any, by the employer.

☐ Use the remaining funds for vision and dental benefits.

Dental: ____________________ **Vision:** ____________________