

ENROLLMENT FORM

1	First Name:	MI:	Last Name:	2	School District Name:	Group No:
Mailing Address:				First day at work:		
City:		State:	ZIP:	OR Special Life Event Date:		
Phone:				Annual salary REQUIRED: \$ _____ (Used to calculate member's included Long-Term Disability benefit)		
SSN:		Gender:	Date of Birth:	Work E-mail:		
				Title/Classification:		Hours Worked / Week:

3 Please select plan type and individual deductible **from the plan or plans offered by your employer**. If you are waiving medical coverage but your employer offers Tailored Dental and/or Vision and you want to enroll, please skip to section 4. By waiving medical coverage you are acknowledging you are also waiving the Basic Life Insurance and Long Term Disability (LTD) provided by the plan, unless you are 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).

PLAN TYPE	INDIVIDUAL DEDUCTIBLE
<input type="checkbox"/> BASIC \$2000 - 70% - \$4000	<input type="checkbox"/> \$ 200 <input type="checkbox"/> \$ 1500 <input type="checkbox"/> \$ 3000 <input type="checkbox"/> \$ 6000
<input type="checkbox"/> COMPREHENSIVE MAJOR MEDICAL (CM)	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 2000 <input type="checkbox"/> \$ 3500
<input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	<input type="checkbox"/> \$ 750 <input type="checkbox"/> \$ 2500 <input type="checkbox"/> \$ 4000
<input type="checkbox"/> REVISED MAJOR MEDICAL (RM)	<input type="checkbox"/> \$ 1000 <input type="checkbox"/> \$ 2700 <input type="checkbox"/> \$ 5000
<input type="checkbox"/> BLUE OPTIONS STANDARD (BO)	
<input type="checkbox"/> BLUE OPTIONS HDHP (BO HDHP)	

4 If offered by your employer, please select Dental and/or Vision coverage.

DENTAL	VISION
Dental No Dental	Vision No Vision

5 Employee must be enrolled in Dental and/or Vision coverage for dependent(s) to enroll in Dental and/or Vision.

DEPENDENT FAMILY MEMBERS	SSN	Date of Birth	Gender M/F	Relationship	Elect Coverage		
					Medical	Dental	Vision
First M Last							

6 **BASIC AND EMPLOYER PAID LIFE INSURANCE-BENEFICIARIES (RETIREES AND TRUSTEES ARE NOT ELIGIBLE)**

Primary – Full Name	Mailing Address	Date of Birth	SSN	Relationship	% of Benefit
Contingent – Full Name	Mailing Address	Date of Birth	SSN	Relationship	% of Benefit

7 **ENROLLMENT AGREEMENT**

I certify that the information on this form is true and accurate. I UNDERSTAND that providing inaccurate or incorrect information on this form may be considered health care fraud.

SIGNATURE OF APPLICANT _____	DATE _____	FOR MUST USE ONLY: Date Entered ____/____/____
		NOTES: _____ Q/A INIT _____