



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 the Market, 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*

SECTION III EMPLOYER CONTRIBUTIONS

Enter your Structure Groups (e.g., certified, classified, administrators, etc.).
For additional Structure Groups, please attach an additional sheet.

Structure Groups: _____

How much does your district contribute to this Group?

Structure Groups: _____

How much does your district contribute to this Group?

Structure Groups: _____

How much does your district contribute to this Group?

Structure Groups: _____

How much does your district contribute to this Group?

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

Dental: _____

Vision: _____