ENROLLMENT FORM

1

First Name:	MI:	Last Name:

Mailing Address:		
City:	State:	ZIP:
Phone:		
SSN:	Gender:	Date of Birth:

2

School District Name:	Group No:
First day at work:	
OR Special Life Event Date:	
Annual salary REQUIRED: $___________________ (Used to calculate member's included Long-Term Disability benefit)	
Work E-mail:	
Title/Classification:	Hours Worked / Week:

3

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 Dental and/or Vision Only, and you want to enroll, skit to section 4. By waiving medical coverage, you are also acknowledging waiver of the Baskic Life Insurance and Long Term Disability (LTD) provided by the medical plan, unless you are covered by MUST as a dependent under anohter policy provided by the same employer. (If covered under another medical coverage, complete the beneficiary section of this application).

PLAN TYPE	INDIVIDUAL DEDUCTIBLE			
☐ **BASIC $2000 - 70% - $4000**	☐ **$ 200**	☐ **$ 1500**	☐ **$ 3000**	☐ **$ 6000**
☐ **COMPREHENSIVE MAJOR MEDICAL (CM)**	☐ **$ 500**	☐ **$ 2000**	☐ **$ 3500**	
☐ **HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**	☐ **$ 750**	☐ **$ 2500**	☐ **$ 4000**	
☐ **REVISED MAJOR MEDICAL (RM)**	☐ **$ 1000**	☐ **$ 2700**	☐ **$ 5000**	

4

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

Dental Benefits ☐ Yes ☐ No

Vision Benefits ☐ Hardware Only ☐ Exam/Hardware ☐ Both ☐ No

5

Employee must be enrolled in Dental and/or Vision coverage for dependent(s) to enroll in Dental and/or Vision.
For section 5 or 6, if additional space is needed please attach a second form completing those sections.

DEPENDENT FAMILY MEMBERS					MEDICAL		DENTAL		VISION			
									Hardware Only		Exam/Hardware	
First Name MI Last Name	Gender	Social Security #	DOB	Relationship	Add	Drop	Add	Drop	Add	Drop	Add	Drop
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐
		- -			☐	☐	☐	☐	☐	☐	☐	☐

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.

_______________________________________ ____________
AUTHORIZED SIGNATURE OF APPLICANT **DATE**

FOR MUST USE ONLY: Date Entered ____/____/____
NOTES:____________________ Q/A INIT__________

Enrollment form revised 02/28/2019