



GROUP ONLINE OPEN ENROLLMENT FORM FOR 7/1 RENEWAL

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. 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 Business Solver, 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. **Please complete all sections of this form and return it with your renewal and life insurance worksheets and the ACA election form by the renewal date deadline.**

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:
(you may only select one)

4/12/21-4/30/21 5/10/21-5/21/21
 4/26/21-5/8/21 5/17/21-5/28/21
 5/3/21-5/14/21 5/24/21-5/28/21

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

ONLY COMPLETE, if:

- A: **Large Groups**—MUST is responsible for your ACA reporting, this section is required.
- B: **All Groups**—Group wants employees to see employer contribution when enrolling online, this section is required.

Enter ALL of your Group's Structure Classifications (e.g., certified, certified part-time, classified, classified part-time, administrators, etc.)
 For additional Classifications, please attach an additional sheet.

Structure Classification: _____

How much does your district contribute to this Structure Classification?

Medical	Amount: _____
Dental	Amount: _____
Vision	Amount: _____

Structure Classification: _____

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