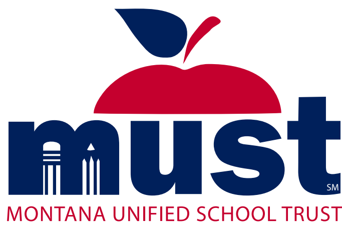


OPEN ENROLLMENT BENEFIT ELECTION FORM

CLERK

Please complete Section 1, Section 2 (Indicate whether or not the group offers dental and/or vision), Section 4 (Plan Type and Details).

1 **Group Name:** **Benefit Period:** ☐ **July** ☐ **September**

2 **DOES GROUP OFFER DENTAL AND VISION BENEFITS?**

Dental Benefits ☐ Yes ☐ No **Vision Benefits** ☐ Hardware Only ☐ Exam/Hardware ☐ No

EMPLOYEE
sections 3-6

Please complete **Section 3**, **Section 4** (mark your plan selection for Medical Benefits), and **Section 5** (add or drop coverage for you and/or your dependents). Please sign and date **Section 6** and submit to your District Clerk.

DO NOT complete this form if you are NOT making any changes to your medical, dental and/or vision benefits. This form is ONLY to be used during the Open Enrollment period to make plan changes.

3	First Name:	MI:	Last Name:	Last 4 of SSN:

Current Plan:

4 **MEDICAL BENEFITS**

EMPLOYEE Mark Selection	CLERK Select Plans Offered by Group	EMPLOYEE Mark Selection	CLERK Select Plans Offered by Group
	No Medical Benefits Plan changes		

5 **MEMBER INFORMATION**
If you are adding or dropping coverage for yourself or dependents, please list the information below.

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

IF DROPPING COVERAGE: I understand that dropping medical coverage completely may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document. I acknowledge that I am also dropping the Basic Life Insurance and Long Term Disability (LTD) benefit provided by the Plan, unless I am covered by MUST as a dependent under another policy provided by the same employer, or employer offers LTD non-medical participant coverage.

6 **I approve the plan changes as indicated above.**

____

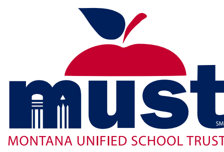
SIGNATURE **DATE**

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: ___________________Q/A INIT__________

Employee Benefit Election Form revised 03/2021

**Please see page 2 for Voluntary Life. If your group does not offer Voluntary Life, please disregard.*



IF YOUR GROUP DOES NOT OFFER VOLUNTARY LIFE, PLEASE DISREGARD THIS PAGE

8	VOLUNTARY LIFE	COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any.

VOLUNTARY COVERAGE (check all that apply) Spouse includes Domestic Partner or Party to a Civil Union as defined in the Certificate.		(A) Add, (C) Change, (D) Delete	Total Amount of Coverage Desired	If (C)hanges, list Prior Coverage
☐ Life / AD&D	Employee			
☐ Life / AD&D	Spouse		5K 10K	
☐ Life / AD&D	Children		5K 10K	

SPOUSE NAME (if Applicant)	LAST	FIRST	M.I.	SEX	SPOUSE DOB	SPOUSE SOCIAL SECURITY #

BENEFICIARY DESIGNATION: (FOR EMPLOYEE ONLY: Must be completed if you have applied for Life/AD&D insurance.)

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to your named surviving primary beneficiaries. If you have no surviving primary beneficiaries, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (NOTE: Employee is the beneficiary of spouse or child coverage proceeds.)

	First Name	Last Name	Social Security #	DOB	Relationship Percentage
Primary					%
Primary					%
Contingent					%
Contingent					%

I hereby request to be insured and authorize deductions, if any, from my compensation. These compensations are for my share of the cost of the benefits to which I may be entitled under the group policy(ies). I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I leave employment that my coverage will terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

EMPLOYEE SIGNATURE ______________________________ DATE ____/____/______

PRINTED NAME ______________________________ GROUP NAME ______________________

WAIVER OF COVERAGE—
I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made by my employer.

EMPLOYEE SIGNATURE ______________________________ DATE ____/____/______

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Enrollment form revised 03/2021