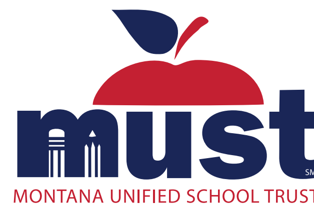
UNIVERSAL FORM



New Enrollees Please complete:
- Sections 1, 2, 10
- Sections 3, 4, 5, 6

If waiving coverage, Please complete:
- Sections 1, 2, 10
- Section 7

Existing MUST Enrollees making changes, Please complete:
- Sections 1, 10
- Sections 3, 5, 6
- Sections 8, 9

Terminating employment Please complete:
- Section 1
- Section 11

This form must be returned to your Business Manager / Clerk. Do not submit directly to MUST.
CLERKS: After review please submit forms to forms@ms-sf.org
***** PLEASE NOTE: Incomplete form will delay enrollment*****

1 First Name:	MI:	Last Name:	2 First day of Paid Status:	OR Special Life Event Date:
Current Mailing Address:			REQUIRED Annual Salary:	
City:	State:	ZIP:	Hours Worked / Week:	☐ Part-Time ☐ Full-Time
Phone:	SSN:		Work E-Mail:	
Gender:	Date of Birth:	School District Name:	Title / Classification:	☐ Classified ☐ Admin ☐ Certified ☐ COBRA ☐ Retiree

NEW ENROLLMENT

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, skip to section 4.

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	☐ $ 2800	☐ $ 5000	

4 If offered by your employer, select Dental and / or Vision coverage.
Employee must be enrolled in Dental and / or Vision coverage for dependent(s) to enroll in Dental and / or Vision.

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

5 For Section 5 or 6, if additional space is needed, please attach a second form and only complete those sections.

EMPLOYEE / DEPENDENT FAMILY MEMBERS					MEDICAL		DENTAL		VISION			
									Hardware Only		Exam/Hardware	
First Name - MI - Last Name	Gender	SSN	DOB	Relationship	Add	Drop	Add	Drop	Add	Drop	Add	Drop

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

Primary - Full Name	Mailing Address	DOB	SSN	Relationship	% of Benefit

Contingent - Full Name	Mailing Address	DOB	SSN	Relationship	% of Benefit

REVISED: 3/11/2022

WAIVER

7 I would like to waive the following benefits.

☐ **All** ☐ **Medical** ☐ **Dental** ☐ **Vision**

LIFE INSURANCE

Are you covered by MUST as a dependent under another policy provided by the same employer? ☐ **Yes** ☐ **No**

Name of person you are covered under: ______________________________

If you answered YES, please list your beneficiaries in section 6

I understand that this waiver 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 waiving 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 participating coverage. (If covered under another medical coverage complete the Beneficiary section of the application -- Section 6)

CHANGE

8 I would like to change the following.

☐ **All** ☐ **Medical** ☐ **Dental** ☐ **Vision**

Please indicate type of change below.

☐ ADDRESS CHANGE (Fill out section 1 with New Address)

☐ NAME CHANGE

Prior Name ______________________________

New Name ______________________________

☐ ADD DEPENDENT

☐ DROP HEALTH BENEFITS

☐ DROP DEPENDENT

(Fill out section 5)

☐ CHANGE BENEFICIARIES (fill out section 6)

☐ STATUS CHANGED TO RETIRED (You must provide Teacher's Retirement or Public Employees Systems documentation.)

DATE: ______________________________

☐ PLAN CHANGE WITH SPECIAL / OPEN ENROLLMENT:

FROM PLAN: ______________ TO PLAN: ______________

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REASON FOR ADD / CHANGE	Date of Event
Birth, Adoption, Legal Guardianship (Attach legal documentation)	
Marriage (Date of marriage required)	
Loss of Other Coverage **REQUIRED:** Reason & Proof of Loss of Coverage ______________________________	
Open Enrollment	

REASON FOR DROP	Date of Event
Divorce or Legal Separation (Provide Address for COBRA notice in "Other")	
Medicare Eligible	
Dropping Health Benefit	
Other Coverage	
Death	
Open Enrollment	
Other	

IF DROPPING COVERAGE: I understand that dropping 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 participating coverage. (If covered under another medical coverage complete section 6 & 7)

ENROLLMENT AGREEMENT

10 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:** ______________

TERMINATION OF EMPLOYMENT

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***Date of Termination:** The date the employee left employment (i.e., last date employee worked as an eligible employee or the last day the employee is eligible for coverage per the terms of the employment contract). All coverage terminations are effective at the end of the month.

****** **Termination Reason:** For Example: resigned, terminated (please indicate whether termination is voluntary or involuntary), Reduction in Force (RIF), hourly reduction (ineligible), death, or termination of employees having waived medical coverage. In case of gross misconduct, the employee is ineligible for COBRA. *MUST* does not determine gross misconduct.

Date of Termination* ______________

☐ Voluntary
☐ Involuntary

Termination Reason **

☐ Gross Misconduct ☐ Hourly Reduction ☐ Death
☐ Resigned ☐ Reduction In Force (RIF)

MUST USE ONLY:

Date Entered: ____/____/____ Q/A INIT ______________

NOTES: ______________________________