South Dakota School District Benefits Fund

HEALTH ENROLLMENT FORM

- - - - EMPLOYER USE ONLY – PLEASE COMPLETE - - - -

☐ NEW COVERAGE ☐ SPECIAL ENROLLMENT ☐ OPEN ENROLLMENT **TYPE OF COVERAGE**: ☐ RETIREE

SPECIAL ENROLLMENT REASON: ☐ MARRIAGE ☐ BIRTH/ADOPTION/PLACEMENT FOR ADOPTION ☐ DIVORCE ☐ COURT ORDERED COVERAGE
☐ RETURNING FROM MILITARY SERVICE ☐ INVOLUNTARY LOSS OF OTHER COVERAGE ☐ LEGAL GUARDIANSHIP ☐ OTHER _____

HIRE DATE	EFFECTIVE DATE	EMPLOYMENT STATUS: FT OR PT _____	SCHOOL DISTRICT MITCHELL	GROUP NUMBER 81407-037A

EMPLOYEE INFORMATION NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SOCIAL SECURITY NO.	SOC SECURITY DISABLED? ☐ YES ☐ NO	MEDICARE ENROLLED? ☐ YES ☐ NO

STREET - MAILING ADDRESS		
CITY, STATE, ZIP	GENDER (M/F)	HOME PHONE NUMBER

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

IF MEDICARE ENROLLED: MEDICARE ID (HIC) #: _____ EFFECTIVE DATES: PART A: _____ PART B: _____

MEDICAL COVERAGE: ☐ EMPLOYEE/SINGLE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILDREN ☐ FAMILY

PLAN OPTION: ☐ $1000 SINGLE DEDUCTIBLE ☐ $1500 SINGLE DEDUCTIBLE ☐ $2500 SINGLE DEDUCTIBLE

I *WAIVE* MEDICAL COVERAGE (PLEASE SELECT ONE):
☐ I (WE) HAVE COVERAGE UNDER ANOTHER HEALTH PLAN ☐ I (WE) DO NOT WISH TO ENROLL IN THE PLAN

If declining coverage, please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

DEPENDENT INFORMATION: PLEASE INDICATE WHO YOU ARE CHOOSING TO COVER

DEPENDENT NAME (FIRST AND LAST)	SEX M/F	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NO	FULL TIME STUDENT? (YES/NO)	SOCIAL SECURITY DISABLED?	MEDICARE ENROLLED? (YES/NO)
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

(LIST ADDITIONAL CHILDREN ON AN ATTACHED SHEET)

OTHER COVERAGE: PLEASE COMPLETE IF MEMBER, SPOUSE, OR DEPENDENT HAS OTHER COVERAGE

LAST NAME	FIRST NAME	MI	POLICY NUMBER	EFFECTIVE DATE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS

IF MEDICARE ENROLLED: NAME OF PERSON(S) COVERED BY MEDICARE: _____

MEDICARE ID (HIC) #: _____ EFFECTIVE DATES: PART A: _____ PART B: _____

PROVIDING SOCIAL SECURITY NUMBERS OR TAX IDENTIFICATION NUMBERS
In order to report my coverage status to the federal government, I understand I must provide my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires the Social Security or tax identification number of the plan member and each dependent. If I do not provide the Social Security numbers or taxpayer identification numbers for this purpose, I may be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ABOVE

_____ _____
EMPLOYEE SIGNATURE **DATE SIGNED**