Enrollment: ☐ New Hire ☐ Open Enrollment ☐ Life Event
Termination: ☐ No Longer Employed ☐ Deceased ☐ Receiving Other Coverage
Change: ☐ Add Dependents ☐ Remove Dependents ☐ Change Name or Address

Employment Status: ☐ Full-Time ☐ Part-Time

Division: ☐ HAESPA ☐ Teamsters ☐ Teachers ☐ Act 93 ☐ Security

- Are you currently already enrolled in insurance with the district through a spouse or parent? _____
- If so, which plans are you currently enrolled in as a dependent? _____

Group # _____ **Effective Date of Coverage (mm/dd/yyyy)** _____ **Date of Hire (mm/dd/yyyy)** _____

NAME **Gender** M / F
Last:
First:
MI:

Address: _____
City: _____
State: _____ Zip: _____
Phone Number: _____

Date of Birth: _____/_____/_____
Social Security Number: _____-____-_____
Annual Salary: $_____

Please select the plan & tier below that is applicable to you:

Medical/Rx: Highmark/CVS	☐ Performance Flex Blue $2,000/$4,000 with HSA	☐ Single	☐ Employee + 1	☐ Employee + 2 or more	☐ Waiving
Medical/Rx: Highmark/CVS	☐ Performance Flex Blue $500/$1,500	☐ Single	☐ Employee + 1	☐ Employee + 2 or more	☐ Waiving
Dental: Delta Dental	☐ PPO Plan Division:_____	☐ Single	☐ Employee + 1	☐ Employee + 2 or more	☐ Waiving
Vision: Davis Vision	☐ 12/24/12 Plan	☐ Single	☐ Employee + 1	☐ Employee + 2 or more	☐ Waiving
Voluntary Life & AD&D:	☐ Mutual of Omaha	☐ Enroll	☐ Waive		

Please enter applicable Dependent information:

☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: _____ City: _____ State: _____ Zip: _____	Social Security Number _____-_____-_____	☐ Male ☐ Female	☐ Spouse DOB ___/___/___
☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: _____ City: _____ State: _____ Zip: _____	Social Security Number _____-_____-_____	☐ Male ☐ Female	☐ Child DOB ___/___/___
☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: _____ City: _____ State: _____ Zip: _____	Social Security Number _____-_____-_____	☐ Male ☐ Female	☐ Child DOB ___/___/___

Please list additional Dependents to be covered:

☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: ____________ City: ____________ State: ____________ Zip: ____________	Social Security Number _____-______-_______	☐ Male ☐ Female	☐ Child DOB ___/___/____
☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: ____________ City: ____________ State: ____________ Zip: ____________	Social Security Number _____-______-_______	☐ Male ☐ Female	☐ Child DOB ___/___/____
☐ Medical ☐ Dental ☐ Vision	Name: Add / Remove	Address: ____________ City: ____________ State: ____________ Zip: ____________	Social Security Number _____-______-_______	☐ Male ☐ Female	☐ Child DOB ___/___/____

Statement of Application:

I hereby apply for the coverage indicated. I understand this application is subject to approval by the carrier, its subsidiaries, and/or reinsurers, and any coverage provided will be subject to the terms of the agreement and/or contracts issued to me. **Any person who knowingly and with intent to defraud or files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I verify that the information supplied by me is correct to the best of my knowledge, information and belief.**

I hereby authorize participation and direct my employer to reduce my salary in the amount necessary to pay for the benefit coverages listed above and understand that this amount will not be subject to Social Security or Federal Income Tax withholding, which may result in a reduction of future Social Security benefits to which I may be entitled. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. I further authorize future adjustments in the amount of the salary reduction in the event the cost of coverage in any program selected is changed by the carrier during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. I am aware that once I have elected to participate in this Plan that I may not revoke my election until the end of the Plan Year with the exception of a Change in Family Status

This election form will remain in effect and cannot be revoked or changed during the plan year, unless revocation and a new election are on account of and consistent with a change in family status.

Waiver of Benefits:

☐ I am electing to waive benefits available through Hazleton Area School District and understand it is my responsibility to obtain medical coverage

______________________________ ______________________
Employee Signature ***Date (mm/dd/yyyy)***

____
Employee Name (Please Print)

Office Use Only: Pro-Rated ______________________________