Employee Enrollment / Change Form

☐ Initial Group ☐ Cobra ☐ Open Enrollment ☐ New Employee ☐ Change (complete Change section on reverse Side.)

EMPLOYER NAME **Augustana College**	GROUP NUMBER **76-412220**	EMPLOYEE ☐ **ACTIVE** ☐ **RETIREE**
EMPLOYEE START DATE	EFFECTIVE DATE	
SOCIAL SECURITY NUMBER	EMAIL ADDRESS	
NAME: LAST	FIRST	M.I.
ADDRESS:	CITY STATE	ZIP CODE

DATE OF BIRTH	GENDER ☐ M ☐ F	MARITAL STATUS	HOME TELEPHONE NUMBER ( )

Do you or any family member currently have other health coverage? **Yes, single** **Yes, family** **No**

If yes to the above question, complete the following: **Person's name** _____ **Employer Name**_____

Carrier Name _____ **Plan Number** _____

Do you or any family member currently have other dental coverage? **Yes, single** **Yes, family** **No**

If yes to the above question, complete the following: **Person's name** _____ **Employer Name** _____
Carrier Name _____ **Plan Number** _____

MEDICAL PLAN: PPO or HDHP	**DENTAL PLAN**	**VISION PLAN**
☐ **Employee**	☐ **Employee**	☐ **Employee**
☐ **Employee plus one dependent**	☐ **Employee plus one dependent**	☐ **Employee plus one dependent**
☐ **Family**	☐ **Family**	☐ **Family**
☐ **Waive**	☐ **Waive**	☐ **Waive**

COMPLETE THIS SECTION BELOW IF ELECTING DEPENDENT COVERAGE. This plan allows all dependents under age 26 to participate in health plan.

SPOUSE NAME: Last, First, MI	**SPOUSE SSN#**	**SPOUSE BIRTH DATE:**	**SPOUSE GENDER**: ☐ M ☐ F

CHILD NAME:	**CHILD'S SSN#**	**CHILD'S BIRTH DATE**	**CHILD'S GENDER**	**RELATIONSHIP TO EMPLOYEE**
1_____	___-___-_____	___/___/___	M F	_____
2_____	___-___-_____	___/___/___	M F	_____
3_____	___-___-_____	___/___/___	M F	_____
4_____	___-___-_____	___/___/___	M F	_____
5_____	___-___-_____	___/___/___	M F	_____

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ **Please specify change and update in appropriate section.**

- ☐ Employee name change
- ☐ Employee address change
- ☐ Job location change
- ☐ Job title change
- ☐ Earnings change
- ☐ Return to work
- ☐ Other coverage change
- ☐ Date of marriage_____
- ☐ Date of Divorce_____
- ☐ Other _____
- ☐ Eligible for Medicaid/CHIP subsidy
- ☐ Loss of Eligibility for Medicaid/CHIP subsidy
- ☐ Add dependents
- ☐ Remove dependents (list names) _____ Reason: _____
- ☐ Add coverage
- ☐ Voluntarily Terminate coverage (Indicate which coverages)
- ☐ State/Federal Continuation

Employee Signature Required

- ☐ Employment termination: Reason:_____ Last day worked_____Date coverage terminated_____

WAIVING COVERAGE

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

☐ I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____ _____

EMPLOYEE SIGNATURE DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

☐ Yes, I authorize my employer to reduce my salary before taxes by the employee contribution amount, as designated by my employer, to cover the premium for my employer-sponsored health insurance plans in which I have elected to enroll.

☐ No, I do not authorize my employer to reduce my salary before taxes by the employee contribution amount, as designated by my employer, to cover the premium for my employer-sponsored health insurance plans in which I have elected to enroll.

I understand that by signing and submitting this form, I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (e.g marriage, divorce, birth of adoption of a child, or termination of spouse's employment.

_____ _____

EMPLOYEE SIGNATURE DATE