

# South Dakota School District Benefits Fund

HEALTH ENROLLMENT FORM



**----- EMPLOYER USE ONLY -- PLEASE COMPLETE -----**

NEW COVERAGE     SPECIAL ENROLLMENT     OPEN ENROLLMENT    **TYPE OF COVERAGE:**     ACTIVE EMPLOYEE     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 MEADE	GROUP NUMBER 81407-061A
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**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? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE ENROLLED? <input type="checkbox"/> YES <input type="checkbox"/> NO
STREET - MAILING ADDRESS				
CITY, STATE, ZIP			GENDER (M/F)	HOME PHONE NUMBER
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED				
IF MEDICARE ENROLLED:    MEDICARE ID (HIC) #: _____    EFFECTIVE DATES: PART A: _____    PART B: _____				

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

PLAN OPTION:     \$1500 SINGLE DEDUCTIBLE     \$2000 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
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