|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL INSURANCE ENROLLMENT FORM** | | | | | *FOR RETIREMENT INFORMATION ONLY*Lump Sum Premium thru Cafeteria:  Yes  No If yes, date deduction begins from retirement benefit: | | | | | | | | | | | | Ret. Plan:  YOS: | | |
|  | | | | | | | | | | | | | | | | | | | |
| NEW ENROLLMENT REFUSAL CHANGE CANCELLATION **EFFECTIVE DATE:** | | | | | | | | | | | | | | |  | | | |  |
| REASON FOR CHANGE: | | | | | | | | | | | | | | | | | | | |
| **SUBSCRIBER INFORMATION** | | | | | | | | | | | | | | | | | | | |
| Name (Last, First MI) | | | | SSN | | | | EmplID | | | Location | | | Employment Status | | | | | |
| Street Address | | | | | | | | | | Primary Contact Number | | | | | | | | | |
| City, State Zip Code | | | | | | | | | | Email Address | | | | | | | | | |
| Gender  Male  Female | Date of Birth | | Marital Status  Single  Married  Divorced | | | | | | | Marriage Date | | | | | | | | Medicare Enrolled\*\*  Yes  No | |
| MEDICAL PLAN ELECTION (Select Plan and Coverage Level) | | | | | | | | | | | | | | | |  | | | |
| **PLAN OPTION:** | **COVERAGE LEVEL:** | | | | | | | | | | | | | | | **MONTHLY PREMIUM** | | | |
| PPO  HDHP | A (SUBSCRIBER ONLY)  B (SUBSCRIBER & SPOUSE)  C (SUBSCRIBER & 1 CHILD) | | | | | | D (SUBSCRIBER & 2 CHILDREN)  E (SUBSCRIBER & FAMILY)  S (SUBSCRIBER & 3+ CHILDREN) | | | | | | | | | **$** | | | |
| **DEPENDENT INFORMATION (Dependents currently enrolled in the Medical Plan)** | | | | | | | | | | | | | | | | | | | |
| Name (Last, First MI) | | SSN | | | | Date of Birth | | | Relationship | | | | Disabled\* | | | | | Medicare Enrolled\*\* | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
|  | |  | | | |  | | |  | | | |  | | | | | Yes  No | |
| \*Indicate disabled status if dependent has a mental and/or physical disability and is incapable of self-support.  \*\*Check “Y” if enrolled in Parts A & B both; and attach a copy of the Medicare card. | | | | | | | | | | | | | | | | | | | |
| COMPLETE THIS PORTION FOR CANCELLATION OR REFUSAL | | | | | | | | | | | | | | | | | | | |
| **Cancellation** I have elected to cancel my Group Hospital Insurance. COBRA members, retirees, surviving spouses and vested members shall not be eligible to re-enroll.  **Refusal** I hereby acknowledge I have been given an opportunity to participate in the MoDOT & MSHP Medical Plan. By refusing this plan at this time, I will be required to provide documentation of a qualifying event if I desire coverage in the future. I understand I have 31 days from my employment date to change my decision and participate in the plan.  **Refusal to Sign** I certify that the benefits of the plans, and the stipulation that enrollment in the future will be subject to a qualifying event if more than 31 days from employment date, were thoroughly explained to the subscriber and he/she has declined to participate and also refused to sign the above statement. | | | | | | | | | | | | | | | | | | | |
| ENROLLMENT ACCEPTANCE | | | | | | | | | | | | | | | | | | | |
| If my application for group insurance is accepted, I hereby authorize MoDOT or MSHP to deduct the amount required to pay premiums on such group insurance from my regular monthly earnings. This authorization shall remain in effect until such time as I notify MoDOT or MSHP to terminate such deductions or this policy is terminated. Misstatements made by a subscriber at the time of enrollment or by a participant at the time of incurred loss may be grounds for denying enrollment or payment of a claim. Please ensure that all dependents meet the dependency requirements of the Plan. | | | | | | | | | | | | | | | | | | | |
| **Subscriber signature** | | | | | | | | | | | | **Date** | | | | | | | |
| **Insurance Representative signature** | | | | | | | | | | | | **Date** | | | | | | | |