SHONTO PREPARATORY SCHOOL
MEDICAL ENROLLMENT FORM

PLAN OPTIONS AND MONTLY CONTRIBUTION AMOUNTS

☐ $0.00 Employee Only ☐ $92.22 Add Spouse ☐ $110.67 Add Dependents ☐ $208.83 Add Family

Member/Employee's Last Name First Name Middle Initial

Date of Birth: Gender: Telephone Number: Social Security Number:

Address: City: State: Zip Code:

Are you or any of your dependents covered under any other health plan? ☐ Yes ☐ No

If yes, Name of Insured: Insurance Company: Insurance Company Telephone Number:

Eligible Dependents To Be Enrolled

Last/First Name	Date of Birth	Relationship	Social Security Number

AUTHORIZATION TO ENROLL FOR COVERAGE

☐ No Coverage (requires a Declination form) • First Health PPO outside Arizona

☐ I authorize payroll deductions for my share, if any, of the cost of the coverages applied for to be taken on a pre-tax basis. I understand by authorizing deductions to be taken on a pre-tax basis only election must be unchanged for 12 months unless I have a change in family status as regulated and mentioned under IRS Section 125 Flexible Spending.

Notice of enrollment rights: I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage maybe subject to treatment as late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after such marriage, birth, adoption, or placement for adoption.

Employee Signature: **Date:**

EMPLOYER/ADMINISTRATOR USE ONLY

☐ New Hire/Date of Hire: ____ / ____ / ____ ☐ Termination Date: ____ / ____ / ____ ☐ Reason for Termination:

☐ Full-Time ☐ Part-Time

Measurement Period Applies ☐ Yes ☐ No ☐ Look Back or ☐ Monthly **FOR HR:** Employee Meets Eligibility: ☐ Yes ☐ No **Initials:**

☐ Add/Delete Dependents (For Open Enrollment provide month/year of Open Enrollment period.) Open Enrollment Date: ____ / ____ / ____

☐ Qualifying event: ____ / ____ / ____ ☐ Marriage ☐ Divorce/Legal Separation Date ☐ New Birth ☐ Adoption ☐ Other:

☐ **Address Change** ☐ **COBRA Continuation** ☐ **Late Enrollee** Coverage Effective Date: ____ / ____ / ____

Department: **Group #204**