SHONTO PREPARATORY SCHOOL MEDICAL ENROLLMENT FORM

□ **Employee Only** □ **Add Spouse** □ **Add Dependents** □ **Add Family**

Member/Employee's Last Name	**First Name**	**Middle initial**

Date of Birth:	**Gender:**	**Telephone No:**	**Social Security No:**

Address:	**City:**	**State:**	**Zip:**

Are you or any of your dependents covered under any other health plan? ☐ **Yes** ☐ **No**
If Yes, Name of Insured: **Insurance Co.:** **Insurance Company Telephone No.:**

Eligible Dependents To Be Enrolled

Last/First Name	**Date of Birth**	**Relationship**	**Social Security No.**

AUTHORIZATION TO ENROLL FOR COVERAGE

- No Coverage (requires a Declination form) • First Health PPO outside AZ
- 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 a 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 ☐ No ☐ Yes - ☐ Look Back or ☐ Monthly **FOR H.R.**: Employee Meets Eligibility: ☐ No ☐Yes-**Initials:** _____

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

Date of qualifying event: _____ / _____ / _____ ☐ Marriage ☐ Divorce/Legal Separation Date ☐ New Birth ☐ Adoption ☐ Other _____

☐ **Address Change** ☐ **COBRA Continuation** ☐ **Late Enrollee**	Coverage Effective Date: _____
Department:	**Group #204**

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