Medical / Dental / Vision Enrollment Form (new hires)

Center Grove Community School Corporation

Hire Date ☐ ADMIN ☐ CERT ☐ SUPP ☐ RETIREE

Employee Last Name | First Name | MI | Sex

Home Address | Soc. Sec. #

City/State/Zip | Birthdate

My Medical Plan Election is (select one):

☐ Employee Only ☐ Employee & Family ☐ No Coverage*

Your medical plan effective date is your hire date.

Office Use Only ☐ CIGNA ________________ ☐ CLINIC ☐ HIPPA

**If you decline enrollment for yourself or your dependents because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the loss of coverage occurs if one or more of the following conditions apply: coverage lost through no fault of your own; loss of employment; divorce or legal separation; death of child and/or spouse. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the event. Otherwise should you desire to apply for this health insurance in the future, you may be ineligible and not accepted for coverage under this health plan.*

My Dental Plan Election is (select one):

Office Use Only ☐ DDPIN

☐ Employee Only ☐ Employee Plus One ☐ Employee & Family ☐ No Coverage

Your dental plan effective date is the first day of the month following your hire date. However, you may request that your coverage begin on your date of hire. If your hire date is between the 1st and the 16th of the month, you will be charged a that month's premium.To request your hire date as your coverage effective date, check here. ☐ (If your hire date is after the 15th of the month, you will not be charged that month's premium.)

Note: Premiums for insurance are paid current. You may have multiple payroll deductions in one payroll check to ensure that your coverage is paid.

My Vision Plan Election is (select one):

Office Use Only ☐ VSP

☐ Employee Only ☐ Employee & Family ☐ No Coverage

Your vision plan effective date is the first day of the month following your hire date. However, you may request that your coverage begin on your date of hire. If your hire date is between the 1st and the 16th of the month, you will be charged that month's premium.To request your hire date as your coverage effective date, check here. ☐ (If your hire date is after the 15th of the month, you will not be charged that month's premium.)

Note: Premiums for insurance are paid current. You may have multiple payroll deductions in one payroll check to ensure that your coverage is paid.

I wish to cover the following dependents under my medical, dental and/or vision plan as indicated below:

Definition of Dependent(s): **Child** - A natural, legally adopted or foster child; a step-child or legal guardian; who is under 24 years of age.
Spouse - Two individuals in a legal union of marriage as defined by Indiana State Law.
Ineligible - Under no circumstances may an employee enroll a sibling, cousin, parent or other dependent relative as a dependent.

	Medical	Dental	Vision	First Name	Last Name	MI	Birth Date	Sex	SSN
SPOUSE	☐	☐	☐						
CHILD	☐	☐	☐						
CHILD	☐	☐	☐						
CHILD	☐	☐	☐						

Do any of these persons listed above (including yourself) have additional medical or dental coverage? ☐ Yes ☐ No

☐ Medical ☐ Dental | ☐ Individual ☐ Family | Name of person with other coverage | Policy #

Name and Address of Insurer | Effective Date

Authorization for Release of Information To: All hospital and other health care providers, insurers, benefit plan sponsors and administrators, and the prescription drug program. On behalf of myself and each of my dependents covered under the health, dental or vision plans for which I have enrolled (the "Plan"), I authorize you to furnish the insurer, the third party administrator of the Plan ("TPA"), its agents and affiliates, with copies of any information and records related to enrollment and any claim made for benefits under the Plan for myself or my covered dependents. I understand that any release or disclosure of information and records concerning the medical condition or treatment of myself, or any ocered dependent, shall only be made as provided under the terms of the administrative services agreement between Center Grove and TPA-i.e., in good faith to the proper parties and as necessary for the proper evaluation and administration of the Plan or as otherwise required by law, regulation, or judicial/administrative order. Where practicable, any such disclosure of my, or my covered dependent(s)' medical condition or treatment shall be made without disclosure of our identity. This authorization shall be valid for the duration of my enrollment in the Plan. **Authorization for Salary Reduction**: I have read the information and understand the benefit choices available tome. I hereby authorize Center Grove to reduce my salary by the amount of the premium for the plans selected. I understand that the coices I have made on this form cannot be changed until the next Open Enrollment period (Dental and Vision only) unless I notify the Benefits Specialist within 30 days of having a qualifying event, as defined by law. **Certification**: I certify that the information I have provided on this form is true and accurate. Any material misrepresentation or deliberate omission of fact may be justification for disciplinary action or termination from Center Grove. I also understand that if any benefit payments are paid/received for persons who do not meet the definition criteria for a dependent, I will be responsible for reimbursing premiums paid by Center Grove and all claims payments.

Employee Signature ______________________ Date Signed ______________

Form and supporting documentation must be received in the Human Resources office within 30 days of your qualifying event date.
Return to: Benefits Specialist, Center Grove HR Department, 4800 W. Stones Crossing Rd., Greenwood, IN 46143 or fax (317) 881-0241
Please keep a copy of this form for your records.