SCHOOL EMPLOYEES BENEFIT TRUST (SEBT) HEALTH PLAN ENROLLMENT/CHANGE FORM

1. EMPLOYEE INFORMATION

Group # A01216 for Allied Benefit Systems

Last Name	First Name M.I.		SS# – –	
Address Apt#	City		State	Zip
Home Phone ( )	Cell Phone ( )	Work Phone ( )	Sex ☐ Male ☐ Female	Birth Date / /
E-mail	Employer Location		Marital Status	☐Single ☐Divorced ☐Married ☐Widowed

2. PLAN SELECTION

Check box to enroll in selected plan.

Medical Plan	☐ Employee	☐	Network Deductible Plan	☐	CDHP Plan - A
	☐ Family	☐	~~CDHP - B~~	☐	CDHP Plan - C

➔ IF WAIVING MEDICAL COVERAGE YOU MUST COMPLETE AND SIGN SECTION 7

3. CHANGE (Qualifying Event)

Effective date of change: / /

Check reason for change: ☐ Newborn ☐ Adoption ☐ Marriage ☐ Divorce ☐ Death ☐ Child no longer eligible

☐ Change in spouse's employment or insurance coverage ☐ Change in dependent status-State reason:

4. FAMILY INFORMATION

List covered dependents. Check this box ☐ if attaching list of additional dependents.

Relationship	*Dependent First Name MI Last Name* *Social Security Number (SS#)*	*Sex*	*Birth Date Mth/Day/Year*	*Child resides with you?*	*Child is your IRS dependent?*	*Full Time Student?*	*Check coverage that apply:*
Spouse	Name__________ SS# – –	☐ M ☐ F	/ /				☐ Medical
☐ Natural ☐ Adopted ☐ Step ☐ Court Order	Name__________ SS# – –	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical
☐ Natural ☐ Adopted ☐ Step ☐ Court Order	Name__________ SS# – –	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical
☐ Natural ☐ Adopted ☐ Step ☐ Court Order	Name__________ SS# – –	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical
☐ Natural ☐ Adopted ☐ Step ☐ Court Order	Name__________ SS# – –	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical
☐ Natural ☐ Adopted ☐ Step ☐ Court Order	Name__________ SS# – –	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical

5. OTHER MEDICAL/RX COVERAGE

Is your spouse employed? ☐ Yes ☐ No

Is your spouse enrolled in his/her employer-sponsored medical plan? ☐ Yes (If "Yes," complete the rest of Section 5 - Other Medical/Rx Coverage.) ☐ No (If "No," you must complete a COB Questionnaire.)

Name and Address of Employer			
Name of Medical Insurance or TPA	Policy Number		
Address of Medical Insurance or TPA	City	State	Zip

List your spouse & dependents with other Medical/Rx coverage. Use the following codes to indicate other coverage for dependents enrolled in SEBT.

1) Employer Provided Medical/Rx *3) TriCare Military Coverage* *5) Medicare/Medicaid* *7) No other coverage*
2) Retirement or Disability Plan Medical/Rx *4) Parent Court Order* *6) Other (Attach Explanation)*

Name	Other Medical	Other Rx Coverage

Please Complete Reverse Side

6. SIGNATURE REQUIREMENT - READ AND SIGN

Any person who knowingly and with intent to defraud, files a statement containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto, commits fraud which is a crime and could jeopardize your coverage.

Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangment may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.

I hereby consent and authorize any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning myself or my dependents to the SEBT or its agents or contractors for the purpose of administering, supervising and monitoring the health Plan(s). I further consent to the subsequent disclosure of medical information concerning myself or dependents by SEBT or its agents or contractors to contractors who provide wellness, disease management, case management or other health and health care related services to SEBT and/ or its participants. This consent shall be valid until revoked in writing by the employee.

Employee Signature	Date
Print Employee Name	

7. WAIVER OF COVERAGE- READ AND SIGN IF YOU REFUSE COVERAGE FOR YOURSELF AND DEPENDENTS.

☐ Waive medical coverage due to: ☐ Have other medical coverage or ☐ Other (Please explain)_____

I understand, if in the future I decide to apply for group medical benefits, I must wait until the next annual open enrollment or enroll as the result of a Qualified Event; and that additional limitation and waiting periods may apply.

Employee Signature	Date
Print Employee Name	

REQUIRED LEGAL DOCUMENTATION

Dependent Type	Submit Copy of Preferred Documentation	Alternate Document
Spouse	Most current federal tax filing (joint or separate); black out finanical detail	In case "Preferred Documentation" is not available, you may use your most recent tax return with the financial detail blacked out in order to prove dependent child status.
Birth Child Under Age 26	Birth certificate	
Adopted Child Under Age 26	Adoption certificate	
Legal Guardianship for Child Under Age 26	Proof of legal guardianship	
Stepchild Under Age 26	Divorce decree identifying medical coverage for dependents	
Appropriate documentation as listed above for dependent spouse and children must be provided to validate eligibility for coverage under the plan.		

TO BE COMPLETED BY EMPLOYER: ***Effective Date of Change: / / Date of Hire: / /***

☐ New Enrollment ☐ Cancellation ☐ Name Change

☐ Re-Enrollment ☐ Open Enrollment ☐ Address Change

☐ Dependent Status Change-State Reason: ☐ Other-State Reason: