BENEFITS APPLICATION / CHANGE FORM

MILWAUKEE PUBLIC SCHOOLS

Employee I.D.: _____

REASON FOR APPLICATION

NEW APPLICATION-(select one)

- ☐ New Employee
- ☐ Return from Leave
- ☐ Current Employee - Newly Eligible

STATUS CHANGE-(select one)

DATE OF EVENT: _____/_____/_____

- ☐ Marriage
- ☐ Divorce
- ☐ Birth/Adoption
- ☐ Death
- ☐ Newly Eligible
- ☐ Termination of Other Coverage
- ☐ Return to Eligible Status

Explanation: _____

COVERAGE ELECTIONS

HEALTH/VISION		DENTAL	
Health Plan Options (select one)	**Coverage Option (select one)**	**Dental Plan Options (select one)**	**Coverage Option (select one)**
☐ PPO UnitedHealthcare ☐ EPO UnitedHealthcare ☐ HDHP UnitedHealthcare ☐ Opt-Out	☐ Single ☐ Family	☐ Delta Dental ☐ Care Plus	☐ Single ☐ Family

EMPLOYEE & DEPENDENTS TO BE ENROLLED

NAME (Please Print) Last, First, Middle Initial	Health	Dental	Date of Birth	Relation to Employee	Sex	Social Security Number	Disabled
Employee (Subscriber)	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___	n/a	☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below

RELATION TO EMPLOYEE – USE THE FOLLOWING CODES
01=Spouse 06=Domestic Partner 02=Child 03=Step Child 04=Legal Ward 05=Grandchild 07=Domestic Partner Child

Employee Spouse or Domestic Partner	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___	(Code)	☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below

List all currently covered and newly eligible dependents/child(ren)and/or Domestic Partner Child(ren)

Dependent(s)	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___	(Code)	☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below
	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___		☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below
	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___		☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below
	☐ Yes ☐ No	☐ Yes ☐ No	___/___/___		☐ F ☐ M	___-___-___	☐ Yes ☐ Medicare Eligible - Complete Medicare coverage below

MEDICARE COVERAGE

Subscriber Name	Medicare #	Health Coverage	Effective Date(s)
		☐ **Part A** ☐ **Part B**	**Part A** ____/____/_____ **Part B** ____/____/_____

I certify that the above information is complete, true, and correct subject to State, Federal, and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependents. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members. I have read and understand the Terms and Conditions on the reverse side of this Benefits Application Change Form, and I have completed the required forms and/or provided documentation. As information requested on these forms changes, I understand I must promptly inform MPS Department of Benefits and Compensation in writing of the changes within 31 calendar days of a qualifying family status change or 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents. MPS reserves the right to determine eligibility and obtain all necessary information to accomplish same. (See Terms and Conditions on reverse side).

Signature: _____ Phone No.: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSTRUCTIONS TO COMPLETE THE BENEFITS APPLICATION/CHANGE FORM
HEALTH / VISION / DENTAL INSURANCE

Please complete the Milwaukee Public Schools Benefits Application/Change Form if: you are enrolling for the first time; making a change to your current coverage as the result of a family status change; or updating your other benefit coverage information.

1) Complete the Milwaukee Public Schools Benefits Application/Change Form by selecting the Reason for Application - New Application or Status Change. If this is a Status Change, you must indicate the Date of the Event.
2) Select the Coverage Option (Single or Family) and the Options for Health/Vision and/or Dental. Please note that there are several Options to choose from for each plan. Note: the only vision provider is National Vision Administrators (NVA); and if you are electing health coverage, you are automatically enrolled in vision coverage. You cannot elect vision only coverage.
   a) If you enroll in Single coverage for Health/Vision and/or Dental, please complete all requested information for yourself (Subscriber).
   b) If you enroll in Family coverage for either Health/Vision and/or Dental, you must complete the Employee Spouse and/or Employee Dependent(s) section of this form for all eligible dependents in addition to yourself, if applicable. Please be sure to check the box, health/vision and/or dental coverage you wish for each dependent. Only ***eligible*** dependents will be accepted. Please refer to the Benefits Summary on the MPS website for detailed information on eligible dependents. LIST ALL DEPENDENTS THAT YOU WISH TO COVER. COVERAGE WILL NOT BE EFFECTIVE FOR ANY DEPENDENTS YOU DO NOT INCLUDE ON THIS FORM.
   c) If you are enrolling dependents other than your spouse, the following are valid options for Dependent(s): Natural or Adopted Child, Grandchild (must meet Dependent Eligibility requirements), Legal Ward/Guardian (documentation of such status is required), and Stepchild. Use the appropriate codes as listed for relation to employee.
   d) If you have a disabled dependent, please indicate this in the appropriate column, and if that dependent is Medicare eligible, please add their Medicare information to the Medicare Coverage section of this form. MPS may request additional information to verify the disabled status of the dependent.
   e) If you are enrolling any dependent(s) you must submit verification of dependent eligibility. For example, if you are enrolling a spouse and/or dependent child(ren), you must submit a marriage certificate and/or birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits and Compensation can delay or possibly prevent the enrollment of your eligible dependents.
   f) If you are enrolling in domestic partner coverage, please refer to the MPS Instructional Guide to Domestic Partner Benefits for enrollment eligibility and requirements.
   g) If you or your dependents have Medicare or Medicaid, please complete the Medicare Coverage section of this form.
3) **Please retain a copy of the Benefits Application/Change Form for your records. We encourage you to return this original form to the Department of Benefits and Compensation in person and bring a copy with you so that we can date and time stamp the copy as received for your records.** If you do not deliver this form in person, please return it to **Milwaukee Public Schools, Office of Human Capital, Department of Benefits and Compensation, 5225 West Vliet Street, Room 124, Milwaukee, WI, 53208.**

TERMS AND CONDITIONS

1) I hereby apply for enrollment/plan membership for the person(s) listed and agree that my dependents and I shall abide by the provisions of coverage in the service agreement under which we are enrolled.
2) I understand enrollment is subject to all of the terms and conditions on the Master Group Policyholder Agreement with the provider I have chosen.
3) I hereby authorize deductions from my earnings of the required contributions, if any, toward the cost of the monthly premium required by Board Policy.
4) I consent and authorize any physician, dentist, consultant, hospital, or other person by whom any diagnosis, medical, surgical or dental treatment, or advice has been rendered to release pertinent medical, surgical, dental reports and records as requested to the insurance plan I selected subject to all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
5) I understand that coverage is effective only upon timely submission of a complete application to MPS and, if applicable, the provider I have chosen.
6) I certify that the above information is complete, true, and correct subject to State, Federal and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependents. MPS reserves the right to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. As information requested on this form changes, I understand I must promptly inform MPS Department of Benefits and Compensation in writing of the changes – within 31 calendar days of a Qualifying Family Status Change or termination of Domestic Partnership, and within 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Refer to the Summary of Benefits on the MPS website or the MPS Informational Guide for Domestic Partnership for additional details. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents.
7) MPS reserves the right to determine eligibility and obtain all necessary information to accomplish this. MPS also retains the right to conduct periodic audits, including random audits for eligibility verification. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members.