BENEFITS ENROLLMENT FORM
School District U-46

- ☐ New Hire
- ☐ Recall
- ☐ Return from Leave
- ☐ Qualifying Event

Please be thorough – fill out all sections that apply & print clearly.

A. Employee Information

First Name	M.I.	Last Name	Social Security #

Street Address	Apt. #	City	State	Zip

Home or Cell Phone #	Personal e-mail Address	Union Affiliation	☐ SEIU ☐ DUEA ☐ DUSA	☐ DUTU ☐ ESSO ☐ ETA	☐ Administration ☐ Non-Union

ID#	Date of Hire	Gender ☐ Male ☐ Female	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

B. Family Information

ATTACH SEPARATE SHEET IF NECESSARY

NAMES OF DEPENDENTS Last	First	M.I.	Social Security Number	Gender	Birth Date	Relationship to Employee
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		

C. Benefits

Dental	Medical		Vision	Health Savings Account
Level of Coverage	**Level of Coverage**	**Type of Coverage**	**Level of Coverage**	**Employee Contribution**
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family ☐ **No Dental Coverage**	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family ☐ **No Medical Coverage** *I have knowingly and willingly decided not to accept this offer, nor exercise my contractual rights.*	☐ PPO Plan Gold ☐ PPO Plan Silver *Both plans are eligible for Health Savings Accounts with Employer contribution*	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family ☐ **No Vision Coverage**	☐ HSA-Health Savings Account Election per pay ___________ ****Please fill out the box below if you are currently in a Medicare plan*

****** PLEASE CHECK IF YOU ARE CURRENTLY ENROLLED IN A MEDIARE PLAN ___________**
Employees enrolled in any Medicare plan will not be eligible for any contributions to the Health Savings Account

D. FSA - Flexible Spending Payroll Deduction Election

☐ Dependent Care Reimbursement	☐ Healthcare Reimbursement
Dependent Care Reimbursement Account ($5,000 Maximum per Year) Election per pay _________________________ (To be used only for reimbursement for daycare expense for your children or for an adult dependent)	Flexible Spending for Healthcare may not be elected if enrolled in either Gold or Silver PPO Plans Election per pay___________________________

FSA - Flexible Spending Payroll Deduction Election (Continued)

As a participant in a Flexible Spending Account (FSA), I understand that I may redirect a portion of my pay to provide benefits under the Plan. The amount of my redirection will be withheld from my paycheck each pay period. Therefore, my employer, School District U-46, is hereby authorized to redirect my compensation in such an amount that is sufficient to provide the benefits I have elected below. I understand that this amount shall be withheld from my paycheck on a pro-rata basis. In accordance with my rights under the Plan, I hereby elect the following benefits which are available under the Plan and designate the following amounts for each benefit I have selected below:
I understand that:

- I may NOT change elections during the Plan Year unless there is a change in my family status (ie. marriage, divorce, death of spouse or child, adoption or birth of child, change in employment status of spouse, emergency medical leave).
- The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code.
- My election will remain in effect only for the Plan Year (January-December) for which these elections are made. Failure to make a new election during Open Enrollment prior to each subsequent Plan Year will be considered an election not to participate in the Plan of the Plan Year.
- Any amounts not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.

I certify that I will not request reimbursement from any other source for these expenses. I understand that reimbursement expense cannot be claimed on my personal income tax return.
I also certify that all expenses, for which reimbursement of payment is claimed, by submission to this plan, were incurred during a period while the undersigned was covered under School District U-46's Flexible Spending Account Plan. With respect to such expenses, for which payment or reimbursement is claimed, it is a proper expense under the Plan. I understand that I may be liable for payment of all related taxes inclining Federal. State or City tax on amounts paid from the Plan which relate to improper expenses. I understand that the automatic rollover feature of the Plan cannot violate the law by creating a double reimbursement and I understand that it is my responsibility to notify the Administrator of any potential violations.

Signature (form must be signed)

I understand that if I wish coverage for myself and/or my eligible dependents, I will not be able to enroll at a later date unless I qualify for a special enrollment as outlined in the HIPAA law. For example: (a.) I am waiving coverage because I am covered under my spouse's/parent's group and they (the group) lose the coverage involuntarily; (b.) I get married; (c.) I have or adopt a child. I understand that I have thirty (30) days from the event date to enroll.

OR

If I apply for coverage as a late enrollee, I will not be covered until the effective date stated in the Employee Group Health & Dental Plan, following the completion of an enrollment form.
I DECLARE THAT I HAVE READ AND UNDERSTAND THE LIMITATIONS IN ENROLLING AT A LATER DATE. I DECLARE THAT THE INFORMATION GIVEN ON THE WAIVER IS CORRECTLY RECORDED AND TRUE.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me for medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that new hires in the School District U-46 health program are required to enroll in the Gold or Silver PPO Plan, until January 1st of the calendar year after your second anniversary of employment with the District.

Date ________________ **Employee Signature** ____

For use by Human Resources

Coverage Effective Date ______________________________ Received Date ________________________

HR Rep. ______________________________________ Date ______________________________

Notes