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Enrollment/Change Form

SECTION I – EMPLOYEE INFORMATION AND COVERAGE ELECTION

Employer Name – Opies Transport	**Group #** 247	**Division -**	**Plan**
Name (First, MI, Last)	**Social Security #**______-_____-________	**Effective Date** _____/_____/_____	
Address (Street, City, State, Zip)	**Telephone**	**Hire Date** _____/_____/_____	
Email Address	**Date of Birth** _____/_____/_____		

❑ **Male** ❑ **Female** **Marital Status** ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Legally Separated** ❑ **Widow/Widower**

❑ **Medical** ❑ **Decline**	❑ **Single** ❑ **EE/Spouse** ❑ **EE/Child(ren)** ❑ **Family**	**Reason for Completing this Form** ❑ **New Hire** ❑ **Part/Full-time Change** ❑ **Late Enrollment** ❑ **Special Enrollment** ❑ **Marriage/Birth/Adoption** ❑ **Terminate Coverage**	**Date of Event/Change** _____/_____/_____

SECTION II – ELIGIBLE DEPENDENTS INFORMATION **Note: This application does not guarantee coverage.**

Name (First, MI, Last)	**Relationship**	**Social Security # -(SSN)** ***Federal law MMSEA requires collection of SSN for all dependents***	**DOB**	**Gender**	**Full-Time College Student**	
Spouse	❑ Spouse ❑ Common Law ❑ Other			❑ **M** ❑ **F**	❑ **Yes** ❑ **No**	**School Name**
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	❑ **Yes** ❑ **No**	**School Name**
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	❑ **Yes** ❑ **No**	**School Name**
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	❑ **Yes** ❑ **No**	**School Name**
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	❑ **Yes** ❑ **No**	**School Name**

SECTION III – OTHER COVERAGE Note: This section must be completed for SISCO to process your dependent claims.

PART A: Spouse (if applicable) **Date of Marriage**

Name & City of Employer ____
Does your spouse have other coverage through his/her employer?
If yes, effective date: ____
If no, are they eligible? ____
☐ No Other Coverage ☐ Single Coverage ☐ Employee and Spouse
☐ Employee and Children ☐ Family Coverage
If family coverage is in place through your spouse's employer, please list the children covered under this plan and what type of coverage exists.
Children's Names: ____
☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
Effective Date of Coverage: ____

Does Spouse have other coverage: ❑ **No** ❑ **Single**
❑ **Employee/Spouse** ❑ **Employee/Children** ❑ **Family**
List children covered and type of coverage (Medical, Dental, Prescription Drug, Vision, etc.)

PART B: Ex-spouse (if applicable) **Divorce Date**

Name
Address
Social Security # ***(if applicable)***
Name and City of Employer
If family coverage is in place through your spouse's employer, please list the children covered under this plan and what type of coverage exists.
Children's Names:______________________________________
☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
Effective Date of Coverage:
Address
Name & City of Employer
List children covered and type of coverage (Medical, Dental, Prescription Drug, Vision, etc.)

Do your spouse or any other dependents have Medicare? ❑ **Yes If yes, who?**________________________ ❑ **No**

SECTION IV – LEGAL PROVISIONS For children listed in section II

Do all the children depend on you for financial support?	❑ Yes	❑ No	If no, who does not?	
Will you claim all children on this year's income tax return?	❑ Yes	❑ No	If no, who will not be claimed?	
Do all the children reside with you more than 6 months a year?	❑ Yes	❑ No	If no, who does not?	
Does a divorce decree or court order assign responsibility for health coverage, or grant tax exemption right for any dependents listed above?	❑ Yes, If yes, please provide copy of decree/court order	❑ No		

SECTION V – SIGNATURE TO ELECT OR DECLINE COVERAGE

Elect: *The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, an/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings. I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments. This consent is subject to revocation at any time.*

Decline: *I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.*
❑ *I do have other coverage*
❑ *I do not currently have other coverage*

Signature	**Date**	**Signature**	**Date**