Trumbull County Schools Insurance Benefits Consortium

Benefits Enrollment Form

☐ Open Enrollment ☐ New Hire ☐ Qualifying Event Effective Date:_

Employee Demographic Information - Please write above the lines

Last Name	First Name	Middle Initial
		L

Street Address	City, State	Zip Code

Hire Date	Social Security Number	Phone Number	Date of Birth

Marital Status	Email

Dependent Information

Coverage	Last Name, First Name	SSN	Relationship	Birthdate	Gender
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental					☐ M ☐ F

Medical - Anthem

	PPO Plan - ($450 Plan) Contributions Shown Are Per Pay Period	HSA Plan - ($1,500 Plan) See Insurance Rep At Your Building	
Employee Only	☐ $ 30.20	☐ $	☐ Waive
Employee + Spouse	☐ $ 63.40	☐ $	
Employee + Child(ren)	☐ $ 51.32	☐ $	
Employee + Family	☐ $ 84.56	☐ $	

Spouse Coordination of Benefits: Spouses of covered employees who are working full-time are required to join their employer's group health plan for at least single coverage where such availability to coverage exists. Please complete the Spouse COB form and return to the Treasurer's Office.

Dental - Delta Dental

	Contributions Added to Medical Above	Stand-Alone Employee Paid Per Pay Period	
Employee Only	☐	☐ $ 13.47	☐ Waive
Employee + Spouse	☐		
Employee + Child(ren)	☐		
Employee + Family	☐		

Vision - Medical Mutual of Ohio

	Contributions Added to Medical Above	Stand-Alone Employee Paid Per Pay Period	
Employee Only	☐	☐ $ $2.88	☐ Waive
Employee + Spouse	☐		
Employee + Child(ren)	☐		
Employee + Family	☐		

Waiver of Coverage

I understand that I have been given the opportunity to apply for the above insurance plans that are offered by The Trumbull County Schools Insurance Benefits Consortium. After careful consideration, I have decided to waive 1 or more of the offered plans. I understand that my election cannot be changed until Open Enrollment 2023 unless I have a qualifying event during the plan year.

Reason for Medical Waiver:

- ☐ Covered by Spouse/Domestic Partner
- ☐ Government Plan: Medicare, Medicaid, State Plan
- ☐ Individual Plan
- ☐ Not affordable
- ☐ COBRA/State Continuation
- ☐ Other - Please explain in space below

_____

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Basic Life Insurance and AD&D			
Enrolled in Automatically	100% employer paid		

Life Insurance and AD&D Beneficiary Information- MUST COMPLETE THIS SECTION				
Primary	Last Name, First Name	Relationship	Social Security Number	% of Benefit
Beneficiary				
Beneficiary				
Beneficiary				
Contingent	Last Name, First Name	Relationship	Social Security Number	% of Benefit
Beneficiary				
Beneficiary				

Note: Total % for both primary and contingent beneficiary must be equal to 100%

Employee Signature - MUST SIGN

I have read, understand, and agree to the following:

I understand that I have met all of the eligibility requirements for participation in the above named benefit plans. I understand that my election cannot be changed until Open Enrollment for the 2023 plan year unless I have a qualifying event during the plan year. I authorize my employer to make appropriate deductions, if any, from my pay per IRS Section 125 Premium Only Plan regulations.

Employee Print Name _____

Employee Signature _____ *Date* _____

Please submit this form to your HR Representative