Reset form

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INDIANA STATE UNIVERSITY
MEDICAL, DENTAL & PRESCRIPTION DRUG APPLICATION

Please Check One:

- ☐ **New Coverage**
- ☐ **Waiving Coverage**
- ☐ **Adding Dependents**
- ☐ **Deleting Dependents**
- ☐ **Special Enrollment**
- ☐ **Open Enrollment**
- ☐ **Premium Conversion Change**
- ☐ **Terminate Coverage**

Staff Benefits Use

Reduct_____Deduct_____

DATE_____Effective/Cancel

EM EC ES ED

Premium Subsidy ____

Wellness Incentive _____

Tobacco Free/Cessation ____

Tobacco Surcharge _____

Waiver_____

Salary:_____

ID#_____

ID#_____

Active	LTD	U-65	COBRA	NEBCO
00123	14057	24861	24935	29167

Name: _____
Last First Initial

University ID Number: _____

Address: _____
Street City State Zip

Birthdate:_____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

☐ **Single** ☐ **Married**

Coverage Effective Date:_____

Date of Marriage:_____

DEPENDENTS TO BE ADDED / DELETED - If deleting, reason for deletion*

Add	Delete*	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender	Relationship

*Reason for coverage termination of dependent _____ Date of termination request_____

OTHER COVERAGE

Are you or any listed dependent presently enrolled in any other health coverage? ☐ YES ☐ NO If yes, a coordination of benefits form must be completed. If you or any listed dependents are covered after your new effective date on the ISU health plan.

ACCEPTANCE OF COVERAGE

- I request membership in the ISU health plan (medical, dental and prescription drug coverage).
- I authorize ISU to withhold contributions for these plans from my pay including any additional contributions required due to effective date.
- I have read and understand ISU's plan eligibility requirements; I certify that the dependents listed on this form meet all eligibility requirements and understand that it is my responsibility to notify the University within 31 days of any changes that would affect their eligibility.
- I understand that enrolling a dependent that is not eligible or failing to provide notice of ineligibility, can result in retroactive termination of health plan coverage for me and my dependents. Coverage of an ineligible dependent will result in liability on my part for costs paid by the plan while my dependent was ineligible.
- I understand that the plan may use my personal health information for the purposes of treatment, payment, and health care operations, and other uses as outlined in the plan's privacy notice, and consistent with federal HIPAA regulations.
- I certify that the information supplied on this form is true and complete; any intentional false information or statements will be grounds to void my coverage.
- I understand that the tobacco surcharge will apply if a Tobacco Affidavit is not completed, signed and submitted to Staff Benefits.

PREMIUM CONVERSION PROGRAM

- Under Section 125 of the Internal Revenue Code, employees may use pre-tax dollars to pay premium rates, thereby reducing taxable income for federal, state, local and Social Security taxes. Along with a reduction in Social Security taxes, participation in this program may also reduce Social Security income at retirement/disability if an employee's salary is below the Social Security Wage Base.
- Each calendar year, you have the opportunity to evaluate your previous decision and make a change by completing a new form.

Please select an option below:

_____**REDUCT (Before Taxes)** _____**DEDUCT (After Taxes)**

Employee Signature_____**Date** _____