Clear Form

INDIANA STATE UNIVERSITY

MEDICAL, DENTAL & PRESCRIPTION DRUG APPLICATION

PLAN CHOICE – you must choose a plan

☐ Traditional PPO Plan ($500 per Individual Deductible/$1,500 Family Aggregate Deductible)

☐ High Deductible Health Plan ($2,000 Employee Only Deductible/ $4,000 EE Plus Dependents Deductible)

Name: _____

University ID Number: _____ Phone: _____

Address: _____

Effective Date: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married, Date of Marriage: _____

Please Check One:

☐ New Coverage
☐ Plan Change
☐ Waiving Coverage
☐ Adding/Deleting Dependents
☐ Special Enrollment
☐ Open Enrollment
☐ Premium Conversion Change
☐ Terminate Coverage

DEPENDENTS TO BE ADDED/DELETED

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

OTHER COVERAGE

Will you or any listed dependent be enrolled in any other health coverage: ☐ Yes ☐ No If yes, a coordination of benefits form must be completed.

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 30 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 Employee 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: _____REDUCT (Before Taxes) _____DEDUCT (After Taxes)

Employee Signature: _____ **Date:** _____

Employee Benefits Office Use

Wellness: EE: _____ SP: _____
Tobacco: EE: _____ SP: _____
Premium Subsidy: _____
HSA Account #: _____

Plan: PPO: _____ HDHP: _____
Reduct: _____ Deduct: _____
Effective/Cancel Date: _____
HSA ER Contribution Amt: _____

EM: __ EC: __ ES: __ ED: __
Act: __ LTD: __ U-65: __ COBRA: __
Ded Code: _____ Plan Code: _____
Pay Event: _____

Anthem: _____
Delta: _____
Access: _____
Banner: _____
PDABCOV: _____