Noble Local Schools

A. EMPLOYER INFORMATION:

Location	Hire Date	Date Waiting Period Began	Effective Date	Network	Basic Life		
	/ /20	/ /20	/ /20	OPPOC	$ -		

Application is for: ☐New Enrollment ☐ Enrollment Change (if change, check below)

☐Add Spouse ☐Add Child(ren) ☐Drop Spouse ☐Drop Child(ren) ☐Change Name ☐Change Address

B. EMPLOYEE INFORMATION:

Last Name	First Name / MI	Sex	Date of Birth	Social Security #	Phone #
		☐Male ☐Female	Mo/Day/Yr / /	- -	

Street Address	City	State	Zip Code	E-mail Address

C. DEPENDENT INFORMATION: (List all dependents to be covered under your chosen plan)

Last Name	First Name / MI	M/F	Date of Birth	Social Security #	Relationship	Add/Drop
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		
			/ /	- -		

D. PLAN OPTIONS: (Please select your plan(s)

Medical Plan(s) Choose One	Enrollment	Dental Plan Choose One	Enrollment	Vision Plan Choose One	Enrollment
☐Noble Local	☐Enrollee Only	☐Elect	☐Enrollee Only	☐Elect	☐Enrollee Only
☐Waive (see back)	☐Family	☐Waive	☐Family	☐Waive	☐Family

Basic Life/Employee

☐Elect
☐Waive $

E. OTHER COVERAGE INFORMATION:

Does your spouse or any dependent have other health insurance? ☐Yes ☐No If yes, provide: Coverage Type ☐Medical ☐Dental ☐Vision

Name(s) of Covered Person(s) _____ Effective Date ___/___/___

Employer _____
Name Address Phone#

Claims Payor _____
Name Address Phone#

F. LIFE/AD&D BENEFICIARY INFORMATION:

Your Death Benefits are to be paid to First Beneficiary(ies):

Name	Relationship	% of Benefits

If First Beneficiary(ies) is not living at your death, benefits are to be paid to Secondary Beneficiary(ies)

Name	Relationship	% of Benefits

ACCEPTANCE:

I hereby apply for group coverage for which I am or may become eligible as elected above. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I understand that I must meet the eligibility requirements of the Plan and that the completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

I elect to have my contribution to the cost of such coverage deducted from my pay on a pre-tax basis. I understand that the cost to me for coverage will be deducted from my gross earnings prior to calculation of certain taxes to be withheld each pay period. I also understand that I may not make any changes in my pre-tax election until the next pre-tax open enrollment period. However, I understand that an election change is permitted due to significant cost or coverage changes to me or a change in my family status as outlined in the Summary Plan Description.

Employee Signature _____ Date _____

DECLINATION:

I hereby decline medical coverage under my employer's medical plan for myself ☐ and/or my dependents ☐ I understand I may not be able to enroll until the next Open Enrollment Period or within 30 days of an event that qualifies as a "Special Enrollment" event.

Employee Signature _____ Date _____

PRE-TAX CONTRIBUTION DECLINATION:

*Check and sign this box **only** if you want your contributions to be subject to payroll taxes*

☐ I do not wish to have my share of the cost, for the coverages I have elected to be deducted from my pay on a pre-tax basis.

Employee Signature _____ Date _____

Waiver of Group Health Benefits

Employee Name

Job Title

Employee Number (ID, Social Security, etc.)

For the plan year effective I am waiving coverage for:

☐ Myself

☐ Spouse

☐ Dependents(s):

If selecting Dependent(s), please list their name(s):

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature Date