Fond du Lac Insurance Company

Benefit Enrollment Form

Section A

Division ☐ 100- Programs ☐ 600- FDLTH ☐ 700- BBC ☐ 800- BBH ☐ 900- BBG

☐ New Enrollment Effective:_____ ☐ Change Effective:_____

☐ Add Dependant Effective: _____ ☐ Cancel Dependant Effective: _____

☐ Other Changes Effective:_____

Section B

EMPLOYEE INFORMATION

Name: | ☐ Male

Social Security Number | ☐ Female

Last *First* *M.I.*

Date of Birth: | Status: ☐ Single ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Widowed | Telephone Number:

Address

Street *City* *State* *Zip Code*

EMPLOYEE TRIBAL ENROLLMENT INFORMATION

Are you: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated

☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

Section C

COVERAGE

	Employee Only	Family	Decline	
Medical	☐	☐	☐	Other_____
Dental	☐	☐	☐	Other_____
Basic Life	☑		☐	Other_____

MEDICAL PLAN SELECTION

☐ **High Deductible Plan**- I understand by choosing this plan there will be no cost to me for Single Coverage; if I choose Family Coverage under the High Deductible Plan the monthly medical premium will be $330.00** per month. I understand that medical premiums will be broken into two payments per month and are on a pretax basis.

Deductibles and Out of Pocket Maximum under the High Deductible Plan will be:

Single Coverage	Family Coverage
$4,000 Deductible	$7,000 Deductible
$5,500 Out of Pocket Max.	$10,000 Out of Pocket Max

☐ **Low Deductible Plan**- I understand by choosing this plan I agree to pay a $130.00 per month premium for Single Coverage; if I choose to elect Family Coverage under the Low Deductible Plan the total monthly medical premium will be $460.00**. I understand that medical premiums will be broken into two payments per month and are on a pretax basis.

Deductibles and Out of Pocket Maximum under the Low Deductible Plan will be:

Single Coverage	Family Coverage
$2,000 Deductible	$3,000 Deductible
$3,400 Out of Pocket Max	$5,800 Out of Pocket Max

** These premiums are for Family Medical only. If you choose Family Dental there is a additional monthly premium of $25.00. Please contact the Benefit Office if you have any question.

******If you are electing Single Coverage please skip to Section E******

Section D

SPOUSE/ DOMESTIC PARTNER INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date:

SPOUSE/ DOMESTIC PARTNER TRIBAL ENROLLMENT INFORMATION

Is your spouse/ domestic partner: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated ☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

DEPENDANT INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date: | Reside with you? ☐ Yes ☐ No | Full Time Student? ☐ Yes ☐ No

Do you claim on Taxes? ☐ Yes ☐ No | ***If student please provide school name below.*

Relationship: ☐ Child ☐ Step Child ☐ Grandchild | Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION

Is your Dependant: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated ☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

DEPENDANT INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date: | Reside with you? ☐ Yes ☐ No | Full Time Student? ☐ Yes ☐ No

Do you claim on Taxes? ☐ Yes ☐ No | ***If student please provide school name below.*

Relationship: ☐ Child ☐ Step Child ☐ Grandchild | Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION

Is your Dependant: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated ☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

DEPENDANT INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date: | Reside with you? ☐ Yes ☐ No | Full Time Student? ☐ Yes ☐ No

Do you claim on Taxes? ☐ Yes ☐ No | ***If student please provide school name below.*

Relationship: ☐ Child ☐ Step Child ☐ Grandchild | Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION

Is your Dependant: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

DEPENDANT INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date: | Reside with you? ☐ Yes ☐ No | Full Time Student? ☐ Yes ☐ No

Do you claim on Taxes? ☐ Yes ☐ No | ***If student please provide school name below.*

Relationship: ☐ Child ☐ Step Child ☐ Grandchild | Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION

Is your Dependant: ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe

Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

DEPENDANT INFORMATION

Name: | Social Security Number

Last *First* *M.I.*

Address: ☐ Male ☐ Female

Street *City* *State* *Zip*

Birth Date: | Reside with you? ☐ Yes ☐ No | Full Time Student? ☐ Yes ☐ No

Do you claim on Taxes? ☐ Yes ☐ No | ***If student please provide school name below.*

Relationship: ☐ Child ☐ Step Child ☐ Grandchild | Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION

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Enrollee Name:

Last *First* *Full Middle*

Name of Federally Recognized Tribe: | Enrollment Number:

Section E

CURRENT SECONDARY AND PREVIOUS COVERAGE

Do you or any covered family member listed on this application, have current secondary health coverage or had previous health coverage with in the last 63 days? ☐ Yes ☐ No If **YES** please fully complete the following section

Starting with the employee, list each family member applying for coverage and include information for all current and previous coverage in effect during the last 18 months.

Member Name	Insurance Company (Name and Claim Address)	Policy Number	Coverage Dates	Reason for Coverage Termination

MEDICARE INFORMATION

Are you or your spouse/ domestic partner covered by Medicare? ☐ Yes ☐ No If **YES** please complete the following selection

Employee: Part A Effective Date _____ **Spouse/ Domestic Partner:** Part A Effective Date _____

Part B Effective Date _____ Part B Effective Date _____

Part D Effective Date _____ Part D Effective Date _____

I understand that providing false information in this application may result in the denial of claims or cancellation of coverage.

Employee Signature *Date Signed*

THIS PART TO BE COMPLETED BY BENEFITS OFFICE

Employee Date of Full-Time Employment	Hourly Wage	Hours worked per week	Plan Number
			767000415580

Indicate the reason employee is enrolling for coverage:

☐ New Employee ☐ Rehire (length of layoff) _____ ☐ Return from leave of absence (length of absence)_____

☐ Previously waived coverage ☐ Change from part-time to full-time ☐ Other_____

Date of event _____

I certify the above information to be true and correct

Benefit Clerk Signature *Date*

CHS Signature authorizing enrollee CHS eligibility *Date*