

## CENTRAL INDIANA SCHOOL EMPLOYEES' INSURANCE TRUST EMPLOYEE ENROLLMENT FORM- DENTAL

The Central Indiana School Employees' Insurance Trust is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for this multiple employer welfare arrangement.

### EMPLOYEE INFORMATION

Last Name	First	Birth Date	Social Security #	Telephone #
	Middle			( )
Home Address	City		State	ZIP
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated ( Date:                      ) <input type="checkbox"/> Divorced (Date:                      )				

### COVERAGE INFORMATION

I elect the following coverages:

								DENTAL/VISION	High Option	Low Option
								Employee	<input type="checkbox"/>	<input type="checkbox"/>
								Family	<input type="checkbox"/>	<input type="checkbox"/>

I WOULD LIKE TO WAIVE COVERAGE UNDER THE TRUST

If you are declining coverage, are you covered under another dental plan?  Yes  No

I UNDERSTAND THAT IF I DO NOT ENROLL IN THE DENTAL PLAN WHEN I AM FIRST ELIGIBLE AND DECIDE TO ENROLL AS A LATE ENROLLEE THAT I AND MY DEPENDENTS WILL ONLY HAVE PREVENTIVE COVERAGE FOR THE FIRST YEAR THAT I/WE ARE IN THE PLAN.

Yes      Members Initials: \_\_\_\_\_

### Other Group Coverage Including Medicare

If other coverage is provided for you or any family member for Medical, Dental or Vision, please provide details below:

Name of Family Member	Type of Coverage (Medical, Dental, Vision)	Name of Insurance Carrier	Group Number

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty days after marriage, birth, adoption, or placement for adoption.

### Eligibility Concerning Your Spouse:

I'm married and carry my spouse as a covered dependent to the Plan. If yes, please provide:

Yes	No	Name:	Sex:	Social Security #:	Birthdate:
-----	----	-------	------	--------------------	------------

If your spouse is employed, please provide the name of the employer.

Does your spouse have other coverage through their employer?  No       Yes      Please indicate coverage:  Medical    Dental    Vision

### Eligibility for Dependent Children of the Employee:

My dependent children, named below meet the following definition:

Yes  No  They are natural children, legally adopted (including a child for whom legal adoption proceedings have been started) and step-children.

Last	Child's Name			DOB	Sex	Relationship			Court Order Requires That I Provide Health Coverage Yes/No
	First	MI				Natural Child	Step Child	Other	
1						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I declare that the information I have furnished above is true, complete and correct.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

### OFFICE USE ONLY

Hire Date	Coverage Effective Date	Plan Administrator Signature _____
Last Day Worked	Coverage Term Date	
Early Retiree Coverage Effective Date (Attach waiver form)		School District/ Location      (circle one)      Blue River      BRC