NORTHFIELD SCHOOL DISTRICT 659 PUBLIC SCHOOLS
ENROLLMENT & ELECTION OF BENEFITS FORM

Employee Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Health Plans

Coverage Level
- ☐ Single
- ☐ Family
- ☐ Waive Coverage

Plan Election
- ☐ $1000/$3000 CMM Plan
- ☐ Health Reimbursement Account (HRA) Plan

Dental Plan
- ☐ Single
- ☐ Family
- ☐ Waive Coverage

Group Life and AD&D Eligible employees are automatically enrolled **100% District Paid**

Voluntary Life **Your Monthly Cost**

Minimum Benefit Amount: $25,000
Increments Purchased: $25,000
Maximum Benefit Amount: $100,000

Premium $_____ / $1,000 X $0.14 = $_____ $_____
(Life amount selected) (monthly premium)

☐ Waive Coverage

All amounts require you to complete an Evidence of Insurability Form and coverage MUST be approved by the carrier.

LIFE INSURANCE BENEFICIARY (GROUP AND VOLUNTARY LIFE): YOU MUST MAKE A BENEFICIARY ELECTION

Primary Beneficiary – this section must equal 100%

Full Name	Social Security #	DOB	Relationship	Percentage

Contingent Beneficiary – this section must equal 100%

Full Name	Social Security #	DOB	Relationship	Percentage

Long Term Disability Eligible employees are automatically enrolled **100% District Paid**

Flexible Spending Account ~ Health Care and Dependent Care: Enroll with e-mail sent by OneDigital

Vision Plan:

☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

LIST ALL INDIVIDUALS WHETHER WAIVING OR ELECTING COVERAGE

Relation	Social Security #	Last Name	First Name	Middle Initial	Date of Birth	Gender M/F	Health Election	Dental Election	Vision Election	Enrolled In Medicare
Self							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect
Spouse							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect
Child							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect
Child							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect
Child							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect
Child							☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect	☐ Waive ☐ Elect

DO YOU OR ANY PERSON LISTED ABOVE HAVE OTHER MEDICAL OR DENTAL COVERAGE? IF YES, YOU MUST COMPLETE THE FOLLOWING:

Insurance Company: _____ Coverage: Medical Effective Date: _____ Policy #: _____

Insurance Company: _____ Coverage: Dental Effective Date: _____ Policy #: _____

Employer through which coverage is held: _____

Names of Individuals above who have this coverage: _____

ENROLLMENT AUTHORIZATION: I have reviewed the enrollment materials and I understand the benefit options and requirements presented therein. I am enrolling for the eligible benefits I indicate on this form the coverage's I want and I authorize reductions from my earnings. I understand and agree that if my eligible expenses for Flexible Spending Accounts do not reach the amount I have allocated to that benefit, I will forfeit any amounts remaining in my participant account at the end of the Plan Year. I assume this risk of forfeiture of monies remaining in my flex accounts. I also understand that all expenses for which I seek reimbursement must be for services performed during the Plan Year, and while I am a participant in the Flexible Benefits Plan. I understand payments for Health and Dependent Care Reimbursement Accounts will be made directly to me. I understand that I cannot revise or revoke this Enrollment Authorization or in any way change the amounts deducted from my salary during the Plan Year, except where there has been a significant change in health coverage attributable to either my employment, or my spouse's employment, or in the case of a change in family status as defined in the Flexible Benefits Plan. I agree to observe the terms and conditions of the Flexible Benefits Plan and all rules and regulations established by the Company to administer the Plan. I understand that the Employer cannot be held responsible for the tax consequences which may or may not result from the benefit(s) I have selected above. This plan is regulated by the Internal Revenue Code Sections 105, 125 and 129, and is subject to discrimination regulations. In the event that the plan is found to be out of compliance with discrimination rules, I may be required to reduce or eliminate my pre-tax deduction election.

_____ _____

Employee Signature **Date**

(Office Use Only)

☐ New hire

☐ Marriage ☐ Dependent reaches student/dependent maximum age

☐ Divorce ☐ Change in employment status for you or your spouse

☐ Death of a dependent ☐ Your spouse commences or terminates employment

☐ Birth/adoption ☐ Unpaid leave of absence by employee

☐ Court order ☐ Address change or name change

☐ Return from leave/layoff ☐ Other _____

Flexible Benefits

Premium Conversion Account ☐ Discontinue Participation Health Care ☐ Discontinue Participation

Dependent Care ☐ Discontinue Participation

Effective Date: _____

Benefit Administrator: _____ Date: _____