Lake Superior State University

BENEFITS ENROLLMENT & CHANGE FORM

ENROLLMENT TYPE: ☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Change of Status

For TERMINATIONS the COBRA Communicator needs to be completed

Demographic Information – Please print clearly and complete all fields

Email forms to: enrollment@44n.com PLAN YEAR STARTING **1-1-2023**	DATE OF HIRE: BENEFIT EFFECTIVE DATE:
EMPLOYEE NAME:	BIRTH DATE:

MAILING ADDRESS: CITY: ST: ZIP:

COUNTY:	EMAIL***:

SSN: ☐ Married ☐ Single ☐ M ☐ F DAYTIME PHONE:

Benefit Elections – Please elect class and coverage or reason for waiving coverage

Class	**BCBS – Medical, Dental, and Vision** **44North – HRA** **Prescription – ARORx/Maxor**	**Reason for Waiving Coverage:**
☐ Faculty ☐ Support Staff ☐ Admin Pro ☐ Low Plan Option	☐ Single ☐ Two-Person ☐ Family ☐ **Delete**	☐ I am covered under another group health plan not offered by this employer (through spouse, self, parent, etc). ☐ I am enrolled in Medicare.

Dependent Information (First, MI, Last) **PLEASE LIST ALL DEPENDENTS ENROLLED**		**Gender**	**Date of Birth**	**SSN**
Spouse ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		
Child ☐ Add ☐ Delete		☐ M ☐ F		

Change of Status – Please check all applicable boxes

This section is only required to be completed if a change is being made outside of the new hire waiting period or open enrollment

Reason for Change:

☐ Change in Employment Status ☐ Loss of Prior Coverage ☐ Marriage ☐ Divorce ☐ Left Employment ☐ Birth

☐ Dependent Aging Out ☐ Other Insurance ☐ Address Change *List new address on front page* ☐ Death

☐ Name Change - Previous Name: ______________________________

Effective Date:

PLEASE CONTINUE & SIGN ON BACK OF FORM

Coordination of Benefits – Please complete all applicable fields if you or a dependent have other coverage				
Name of Insurance Carrier(s):				TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY
Medical, Dental, and/or Vision Coverage	Group Number(s):			
Medicare Enrollee	☐ Self	Medicare Member ID:		☐ Age ☐ Disability ☐ ESRD**
Medicare Enrollee	☐ Spouse ☐ Dependent	Medicare Member ID:		☐ Age ☐ Disability ☐ ESRD**
Medicaid/ Other	Enrollee Name:		Eligible Dependent Member ID:	
Medicaid/ Other	Enrollee Name:		Eligible Dependent Member ID:	

** If you, your spouse or any dependent(s) listed are enrolled in Medicare, please attach a copy of your Medicare card(s)*
***ESRD: End-Stage Renal Disease*

Certification – By signing this form I certify that these are my benefit elections and that:

I understand that having agreed to enroll, that I will have no right to participate in the benefit plans and that these benefits will not be available to me, until I have completed, signed and returned the enrollment form and my enrollment is accepted. I understand that as of the first day of the plan year, this agreement cannot be changed or revoked during the plan year, unless I experience a qualified change in my family status as defined in the Plan Documents. I understand that coverage applies only to expenses incurred during my participation in the plan.

Employee Signature: ______________________________ **Date:** ______________

Administrator Signature: ______________________________ **Date:** ______________