Intermediate Unit #1
Health Care Consortium

ENROLLMENT/CHANGE FORM

SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level. **Return this completed form within 31 days of your full-time date of hire or qualifying event, along with any required documentation i.e. marriage certificate, birth certificate, etc.**

Reason For Completing This Enrollment Form: ☐ New Hire ☐ Current Employee Enrolling ☐ Change

Type of change: ☐ Address ☐ Name ☐ Add Spouse/Dependent ☐ Remove Spouse/Dependent

Hire Date: | Benefit Type (check all that apply): ☐ Medical ☐ Dental ☐ Vision

Name (First, Middle, Last)	**Social Security Number**	**Date of Birth**	**Male/Female**	**Add or Drop**
Employee/Retiree			☐ M ☐ F	
Spouse			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	
Dep			☐ M ☐ F	

Street Address		
City	State	Zip Code

Required Documentation Provide the required document along with this form. Refer to the Instructions for Benefit Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

I certify that the above information is true and correct. For New Hire: By not enrolling in certain benefits at this time (within 31 days of full-time date of hire or within 31 days of a qualifying change in family status), I understand that I will be unable to enroll or make changes again until the next annual Open Enrollment period.

Signature of Employee/Retiree: Date:

SECTION II - TO BE COMPLETED BY SCHOOL DISTRICT

District: | Representative:

Effective Date of Change: | Date Section I Received:

Group #s	**Old** (if applicable)	**New**	**Coverage Level/Tier**
Medical			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM
Dental			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM
Vision			☐ EE ☐ EE+CH ☐ EE+CHN ☐ EE+SP ☐ FAM

Type of Activity (check all that apply):

☐ New Hire
☐ Current Employee Enrolling
☐ Termination
☐ Add Spouse/Dependent
☐ Remove Spouse/Dependent
☐ Change of Address
☐ Name Change
☐ Act 110 / Act 43 Eligible
☐ COBRA (check all that apply and indicate Qualifying Event below)
☐ Medical ☐ Dental ☐ Vision

Qualifying Event or Change of Family Status:

☐ Newborn
☐ Adoption
☐ Retirement
☐ Marriage
☐ Divorce
☐ Death
☐ Voluntary Resignation
☐ Involuntary Resignation
☐ Legal Guardianship
☐ Court Ordered
☐ Over Age Dependent
☐ Medicare Entitlement
☐ Other _____

Required documentation must be collected, reviewed and approved by district prior to enrollment. DO NOT sent documentation to ReSo; keep at district for auditing purposes.

Signature of District Rep: Date:
-required for processing -