SISIT
Southeastern Indiana School Insurance Trust

SOUTHEASTERN INDIANA SCHOOL INSURANCE TRUST
EMPLOYEE ENROLLMENT FORM

Batesville Schools Use Only

Employee Date of Hire:	Employee Occupation:	Coverage Effective Date:
Is Income Reported by W-2?	Hours Worked Per Week:	Retirement Date:

Section A – Waiver of Coverage (*This section must be completed for employee and / or any eligible dependent not enrolling the group health plan when initially eligible due to coverage elsewhere)*

Name of person waiving:	Coverage is provided by Spouse Parent No Coverage
Name of person waiving:	Coverage is provided by Spouse Parent No Coverage
Name of person waiving:	Coverage is provided by Spouse Parent No Coverage
Name of person waiving:	Coverage is provided by Spouse Parent No Coverage

I certify that I have been given an opportunity to apply for group health coverage through the Trust and I am declining as indicated above. I understand that I will be able to enroll in the future only during the next annual open enrollment period, OR if I or my eligible dependent(s) experience a qualifying event as defined by HIPAA guidelines. I also understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents at that time. All enrollment forms must be received within *31* days of the event.

Employee Signature _____ **Date** _____

Section B – Medical Coverage Selection Information

Circle One	Active M055	Retiree MR55	COBRA MC55	Active M056	Retiree MR56	COBRA MC55	Active M057	Retiree MR57	COBRA MC57
Employee	☐	PPO 1		☐	HDHP 1		☐	HDHP 2	
EE/Child(ren)	☐	PPO 1		☐	HDHP 1		☐	HDHP 2	
EE/Spouse	☐	PPO 1		☐	HDHP 1		☐	HDHP 2	
Family	☐	PPO 1		☐	HDHP 1		☐	HDHP 2	

Section C – Dental Coverage Selection Information

☐ **Employee** ☐ **Family**

Section D – Vision Coverage Selection Information

☐ **Employee** ☐ **Family**

Section E – Employee/Application Information (all fields must be completed)

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy	☐ Single ☐ Married ☐ Divorced

Home Address (include PO Box if applicable)	City	State	Zip

Home Phone ( )

Work Phone ( )

Email Address

Document Preference ☐ NO PRERENCE ☐ ONLINE ☐ PAPER

Section F – Spouse Information (all fields must be completed)

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy

Section G – Family Information – (all fields must be completed for each covered dependent)

First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy

Section H – Other Health Coverage

List yourself and any family members to be enrolled in this plan who will be covered by other health coverage on this plan's effective date:

Provide name & address of insurance carrier:_____

Policyholder Name:_____ Relationship to Employee:_____

Group/Account/Policy ID Number:_____ Effective Date of Coverage:_____

If you and/or your dependent(s) are enrolled in Medicare or Medicaid, please complete the following:

Enrollees Name:	Medicare/Medicaid ID #	Medicare Part A Effective Date:	Medicare Part B Effective Date:

Section I – Prior Health Coverage

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years?

☐ Yes (*complete information below)*

☐ No

List yourself and any other family members who have had prior coverage:	Name of Insurance Carrier: Group/Account/Policy ID Number: Coverage Effective Date: Coverage Termination Date: Reason for Termination: ☐ Divorce/Legal Separation ☐ Death of Spouse ☐ COBRA Coverage Exhausted ☐ Termination of Employment ☐ Employer Premium Contribution Ceased ☐ Other - Please explain_____ _____

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. All enrollments must be submitted within *31* days of the qualifying event. All required documentation must accompany this form in order to process the enrollment.

By signature, I declare that the information provided is complete and correct. By electing coverage under this Plan, I also agree to have the applicable premium deductions made. I accept that I am responsible to notify my employer of any change that would make me or any dependent ineligible for benefits under the Trust group health plan.

Employee Signature: _____ **Date:** _____

Your coverage is issued by a multiple employee welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

SISIT Office Use Only

Spouse: Marriage Certificate _____ **Child:** Birth Certificate _____ UHC _____

Current Tax/Bill Doc _____ Court Order/Adoption Decree _____ 2024