PSATS TRUSTEES INSURANCE AND RETIREMENT SERVICES

Enrollment Form

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Entity Name
(This is the Township, Municipality or Authority name)

County

Employee First Name **M.I** **Last Name**

Employee Email Address

Occupation

Employee Street Address **City** **State** **Zip Code**

Date of Birth (mm/dd/yyyy) / /

Employee Social Security Number - -

Gender M F

Fulltime Start or Rehire Date / /

The **Fulltime Start or Rehire Date** is the employee's first day of work or date rehired into an eligible status (i.e. return from layoff within 90 days).

Individuals Covered – List individuals for whom you are adding/changing/removing coverage

(A)dd (C)hange (R)emove (W)aiver	Coverage Type see code below	First Name	Middle Name	Last Name	Relationship (Self, Spouse, Child)	Sex M-F	Birthdate MM/DD/YYYY	Social Security # (if dependent has no SSN, write "NONE")	College Student (Y/N)

COVERAGE Type Codes: Your employer will inform you of available coverage.

Medical - M **Dental - D** **Vision - V** **Vision Grp No. 4115__________** **Life/AD&D - L**

PSATS will complete the above numbers

Short Term Disability Yes No

Plan # (1,2,3)

Annual Salary $. 0 0
Salary, weeks, and hours must be completed for Plan 3 members

Weeks Worked Per Year

Hours Worked Per Week

Beneficiary Information: Must be completed for anyone enrolling in life insurance.

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Internal PSATS use only

PSATS ID # A

Member ID # C

Effective Date / /

Declining coverage – Check all that apply.

This section must be completed if the employee is not enrolling for even just one product offered by the employer or if any of their dependents are not enrolling in eligible products. It is NOT necessary to waive products not offered by the employer.

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee:	☐ Medical ☐ Med Advantage ☐ Life/AD&D	☐ Dental ☐ Vision ☐ ST Disability	Reason for declining coverage ☐ Parental group coverage ☐ Spouse/domestic partner group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA coverage
☐ Spouse/ domestic partner:	☐ Medical ☐ Med Advantage	☐ Dental ☐ Vision	☐ Insurance through another job ☐ TRICARE/Military coverage ☐ Individual coverage – On Exchange ☐ Individual coverage – Off Exchange ☐ Another group plan provided by my employer ☐ Do not want ☐ Other________________
☐ Children:	☐ Medical ☐ Med Advantage	☐ Dental ☐ Vision	

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependents. **Date (Month/Day/Year)**

Must be signed if employee or dependents are waiving any of the offered products.

☐ **I am declining coverage. Employee signature: X**

Please PRINT employee name:

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Signature required if enrolling in any product.

Employee Signature ______ Date ______ Work Phone ______ Home Phone ______

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYEE

Employer Signature ______________________ Date: ______________

Employer signature required on all enrolling or waiving forms.