OEA Choice Trust

ENROLLMENT APPLICATION AND CHANGE OF INFORMATION FORM

☐ New
☐ Change

School District Name: HILLSBORO SCHOOL DISTRICT Date of Hire: _____ Effective Date: _____

Employee Soc Sec #: _____ Employee Name: _____

Employee Date of Birth: _____ Male ☐ Female ☐ Phone: (H) _____ (W) _____

Address: (✓ only if new ☐) _____
City State Zip

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Single

Classification: ☐ Admin/Conf ☐ Certified ☐ Classified ☐ COBRA ☐ Retiree ☐ Full Time ☐ Part Time

To **change address**: complete address section above ↑; to **add Dependent**: complete dependent section below ↓ (list reason); to **drop Dependent(s)**: list dependent(s) being terminated in section below ↓ (list reason); to **change name**: note effective date and old/new names below ↓.

Former Name _____ New Name _____ Eff Date _____

❁ **SP** (Spouse) **S** (Son) **D** (Daughter) **DP** (Domestic Partner) **Other** (Specify Relationship)

Add + / Drop -	List all family members to be covered under this plan. Dependent(s) Full Name	Soc. Sec. No.	❁ (See Above) Relation	Sex M/F	Date of Birth Mo	Day	Yr	Full-time Student	
								☐ Yes	☐ No
								☐ Yes	☐ No
								☐ Yes	☐ No
								☐ Yes	☐ No
								☐ Yes	☐ No
								☐ Yes	☐ No

➢ **Reason for add or drop** _____ To add/drop additional dependents, use back ➔

Check box(es) to designate desired coverage(s) **Indicate Plan Name:**	EE Only	EE + One	EE + Family
☐			
☐			
☐ Dental **Plan Name:**			
☐ Vision **Plan Name**:			
☐ Long-Term Disability (LTD) ☐ Short-Term Disability (STD)			
Life Products: ☐ Group Term Life ☐ Supplemental Life ☐ Dependent Life ☐ Negotiated Life			

Do you or any of your dependent(s) have any other health insurance? ☐ Yes ☐ No If yes, please indicate: ☐ Medical ☐ Dental ☐ Vision ☐ Medicare

List those insured: _____ _____ _____

Medical Carrier _____ Dental Carrier _____ Vision Carrier _____

Effective Date _____ Effective Date _____ Effective Date _____

Life Insurance Beneficiary. **Designate percentage for each beneficiary. Total must equal 100%**. This signed form supercedes any previously signed Enrollment or Change of Status Form.

	Name (Please Print)	Relation	Percent
Primary Beneficiary			
Secondary Beneficiary			
Third Beneficiary			

(**Total** must equal 100%): **Total**

Please read and sign below. **(form must be signed by employee to activate insurance/changes)**

I hereby authorize any medical care institution or medical provider to give my insurance carriers any information related to the physical or mental condition, medical history, or medical treatment of me or my family members requested in the underwriting of my application or in administering claims under my plan(s). This authorization will remain valid so long as I remain eligible for benefits.

To the best of my knowledge, the information provided on this form is complete and true, and I understand that falsification by me will allow my insurance carriers to recover payment made, cancel my membership and/or refuse to pay claims.

I agree to the terms of this application.

_____ Employee Signature _____ Date

OEA Choice Trust
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