



# Fond du Lac Insurance Company

## Benefit Enrollment Form

### OPEN ENROLLMENT

#### Section A

<b>Division</b>	<input type="checkbox"/> 100- Programs	<input type="checkbox"/> 600- FDLTH	<input type="checkbox"/> 700- BBC	<input type="checkbox"/> 800- BBH	<input type="checkbox"/> 900- BBG
<input type="checkbox"/> New Enrollment Effective: _____	<input type="checkbox"/> Change Effective: _____				
<input type="checkbox"/> Add Dependant Effective: _____	<input type="checkbox"/> Cancel Dependant Effective: _____				
<input type="checkbox"/> Other Changes Effective: _____					

#### Section B

EMPLOYEE INFORMATION					
Name:					<input type="checkbox"/> Male
Social Security Number					<input type="checkbox"/> Female
<i>Last</i>	<i>First</i>	<i>M.I.</i>			
Date of Birth:	Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed			Telephone Number:	
Address					
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>		
EMPLOYEE TRIBAL ENROLLMENT INFORMATION					
Are you: <input type="checkbox"/> Enrolled in a Federally Recognized Tribe <input type="checkbox"/> Non-Tribal Affiliated <input type="checkbox"/> Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe					
Enrollee Name:					
<i>Last</i>	<i>First</i>	<i>Full Middle</i>			
Name of Federally Recognized Tribe:			Enrollment Number:		

#### Section C

COVERAGE					
	Employee Only	Family	Decline	Other _____	
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	
Basic Life	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	

#### MEDICAL PLAN SELECTION

**High Deductible Plan-** I understand by choosing this plan there will be no cost to me for Single Coverage; if I choose Family Coverage under the High Deductible Plan the monthly medical premium will be \$330.00\*\* per month. I understand that medical premiums will be broken into two payments per month and are on a pretax basis.

Deductibles and Out of Pocket Maximum under the High Deductible Plan will be:

Single Coverage	Family Coverage
\$4,000 Deductible	\$7,000 Deductible
\$5,500 Out of Pocket Max.	\$10,000 Out of Pocket Max

**Low Deductible Plan-** I understand by choosing this plan I agree to pay a \$130.00 per month premium for Single Coverage; if I choose to elect Family Coverage under the Low Deductible Plan the total monthly medical premium will be \$460.00\*\*. I understand that medical premiums will be broken into two payments per month and are on a pretax basis.

Deductibles and Out of Pocket Maximum under the Low Deductible Plan will be:

Single Coverage	Family Coverage
\$2,000 Deductible	\$3,000 Deductible
\$3,400 Out of Pocket Max	\$5,800 Out of Pocket Max

\*\* These premiums are for Family Medical only. If you choose Family Dental there is a additional monthly premium of \$25.00. Please contact the Benefit Office if you have any question.

\*\*\*If you are electing Single Coverage please skip to Section E\*\*\*

**Section D**

SPOUSE/ DOMESTIC PARTNER INFORMATION	
Name:	Social Security Number
<i>Last</i> <i>First</i> <i>M.I.</i>	
Address:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i> <i>City</i> <i>State</i> <i>Zip</i>	
Birth Date:	

SPOUSE/ DOMESTIC PARTNER TRIBAL ENROLLMENT INFORMATION	
Is your spouse/ domestic partner:	<input type="checkbox"/> Enrolled in a Federally Recognized Tribe <input type="checkbox"/> Non-Tribal Affiliated <input type="checkbox"/> Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe
Enrollee Name:	
<i>Last</i> <i>First</i> <i>Full Middle</i>	
Name of Federally Recognized Tribe:	Enrollment Number:

DEPENDANT INFORMATION	
Name:	Social Security Number
<i>Last</i> <i>First</i> <i>M.I.</i>	
Address:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i> <i>City</i> <i>State</i> <i>Zip</i>	
Birth Date:	Reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No      Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you claim on Taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>**If student please provide school name below.</i>
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild	Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION	
Is your Dependant:	<input type="checkbox"/> Enrolled in a Federally Recognized Tribe <input type="checkbox"/> Non-Tribal Affiliated <input type="checkbox"/> Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe
Enrollee Name:	
<i>Last</i> <i>First</i> <i>Full Middle</i>	
Name of Federally Recognized Tribe:	Enrollment Number:

DEPENDANT INFORMATION	
Name:	Social Security Number
<i>Last</i> <i>First</i> <i>M.I.</i>	
Address:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i> <i>City</i> <i>State</i> <i>Zip</i>	
Birth Date:	Reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No      Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you claim on Taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>**If student please provide school name below.</i>
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild	Name of School

DEPENDANT TRIBAL ENROLLMENT INFORMATION	
Is your Dependant:	<input type="checkbox"/> Enrolled in a Federally Recognized Tribe <input type="checkbox"/> Non-Tribal Affiliated <input type="checkbox"/> Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe
Enrollee Name:	
<i>Last</i> <i>First</i> <i>Full Middle</i>	
Name of Federally Recognized Tribe:	Enrollment Number:

DEPENDANT INFORMATION			
Name:		Social Security Number	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	
Address:			<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Birth Date:	Reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you claim on Taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No	**If student please provide school name below.	
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild	Name of School		

DEPENDANT TRIBAL ENROLLMENT INFORMATION	
Is your Dependant: <input type="checkbox"/> Enrolled in a Federally Recognized Tribe <input type="checkbox"/> Non-Tribal Affiliated <input type="checkbox"/> Child or Grandchild of an Enrolled Member of a Federally Recognized Tribe	
Enrollee Name:	
<i>Last</i>	<i>First</i> <i>Full Middle</i>
Name of Federally Recognized Tribe:	Enrollment Number:

DEPENDANT INFORMATION			
Name:		Social Security Number	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	
Address:			<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Birth Date:	Reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you claim on Taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No	**If student please provide school name below.	
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild	Name of School		

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Enrollee Name:	
<i>Last</i>	<i>First</i> <i>Full Middle</i>
Name of Federally Recognized Tribe:	Enrollment Number:

DEPENDANT INFORMATION			
Name:		Social Security Number	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	
Address:			<input type="checkbox"/> Male <input type="checkbox"/> Female
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Birth Date:	Reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you claim on Taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No	**If student please provide school name below.	
Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild	Name of School		

DEPENDANT TRIBAL ENROLLMENT INFORMATION	
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Enrollee Name:	
<i>Last</i>	<i>First</i> <i>Full Middle</i>
Name of Federally Recognized Tribe:	Enrollment Number:

**Section E**

**CURRENT SECONDARY AND PREVIOUS COVERAGE**

Do you or any covered family member listed on this application, have current secondary health coverage or had previous health coverage with in the last 63 days?  Yes  No If **YES** please fully complete the following section

Starting with the employee, list each family member applying for coverage and include information for all current and previous coverage in effect during the last 18 months.

Member Name	Insurance Company (Name and Claim Address)	Policy Number	Coverage Dates	Reason for Coverage Termination

**MEDICARE INFORMATION**

Are you or your spouse/ domestic partner covered by Medicare?  Yes  No If **YES** please complete the following selection

<b>Employee:</b>	Part A Effective Date _____	<b>Spouse/ Domestic Partner:</b>	Part A Effective Date _____
	Part B Effective Date _____		Part B Effective Date _____
	Part D Effective Date _____		Part D Effective Date _____

**I understand that providing false information in this application may result in the denial of claims or cancellation of coverage.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

**THIS PART TO BE COMPLETED BY BENEFITS OFFICE**

Employee Date of Full-Time Employment	Hourly Wage	Hours worked per week	Group Number <b>PKA20381</b>
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**Indicate the reason employee is enrolling for coverage:**

New Employee  Rehire (length of layoff) \_\_\_\_\_  Return from leave of absence (length of absence) \_\_\_\_\_  
 Previously waived coverage  Change from part-time to full-time  Other \_\_\_\_\_

Date of event \_\_\_\_\_

**I certify the above information to be true and correct**

\_\_\_\_\_  
*Benefit Clerk Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*CHS Signature authorizing enrollee CHS eligibility*

\_\_\_\_\_  
*Date*