# EMPLOYEE APPLICATION

7605 Westfield Blvd.
Fort Wayne, IN 46825

**SECTION A: EMPLOYEE INFORMATION (PLEASE PRINT IN INK)**

| Full Name (Last, First, Middle Initial) | Employee Social Security Number / / | ☐ Male ☐ Female | Date of Birth / / (Mo/Day/Yr) |
|---|---|---|---|
| Home Address | City, State, Zip Code | Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Legally Separated | |
| Employers Name **#6926 Wabash City Schools** | Occupation: | Hire Date: | Contact Phone #: |

**SECTION B: DEPENDENT INFORMATION-You must list all dependents, even those not covered by the plan**

| | Last Name, First Name & Middle Initial | Dependent SSN # | Birthdate (Mo/Day/Yr) | Sex (M/F) | Relationship (check one) Natural Child | Adopted Child | Step-Child | Legal Guardian *A | Eligible For Other Insurance (Y/N) | To Be Covered By The Plan (Y/N) |
|---|---|---|---|---|---|---|---|---|---|---|
| SPOUSE | | | | | | | | | | |
| CHILD | | | | | | | | | | |
| CHILD | | | | | | | | | | |
| CHILD | | | | | | | | | | |
| CHILD | | | | | | | | | | |
| CHILD | | | | | | | | | | |

*A. If to be covered, please attach to the Enrollment Form copies of the court orders or legal documents creating this relationship.

**SECTION C: EMPLOYEE AND DEPENDENT BENEFIT SELECTION-This section must be completed in full.**

**Health Coverage Selection:**

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Spouse & Child(ren)
- ☐ Waive Health Coverage

Reason for waiving: ________________

**Health Plan Selection:**

- ☐ $750 Deductible (Traditional) Plan 1
- ☐ $3,000 HDHP (H.S.A) Plan 2
- ☐ $5,000 HDHP (H.S.A.) Plan 3

**Network Selection:**

- ☐ Signature Care EPO
- ☐ Encore/Encircle EPO

**Dental Coverage Selection:**

- ☐ Employee Only
- ☐ Employe & Spouse
- ☐ Employe & Child(ren)
- ☐ Employee & Spouse & Child(ren)
- ☐ Waive Dental Coverage

**Vision Coverage Selection:**

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employe & Child(ren)
- ☐ Employee & Spouse & Child(ren)
- ☐ Waive Vision Coverage

1. Are YOU or any of YOUR DEPENDENTS COVERED by the HEALTH BENEFIT PLAN CURRENTLY PROVIDED BY THIS EMPLOYER?
   Yourself ☐Yes ☐No Your Spouse ☐Yes ☐No or your Child(ren) ☐Yes ☐No
2. Are YOU covered by other group insurance? ☐Yes ☐No, or your Spouse ☐Yes ☐No or your Child(ren) ☐Yes ☐No
   If Yes, List Other Carrier Information: ________________________________

**SECTION D: Only to be completed by employee enrolling after plan effective date.**

Group # ______________ Location # ________________________ ☐ New Hire

☐ Loss of Coverage (Circle One): Termination of Spouse's Employment, Reduction in Hours, Expiration of COBRA

☐ Acquire New Dependent (Circle One): Marriage, Birth, Adoption, Placement of Child

☐ Previously Eligible and Declined Coverage ☐ Other: ________________________________

**Provide prior employer or insurance company Certification of Creditable Coverage**

| **Home Office Use Only:** | Group No: | Eff. Date: | Life: | WI: | Rx Card: | ID Card: | SPD: |
|---|---|---|---|---|---|---|---|

**EMPLOYER NAME:** #6926 Wabash City Schools **EMPLOYEE NAME:** ______________________

## MEDICARE & MEDICAID

1. Are YOU or any of YOUR DEPENDENTS covered by MEDICARE or MEDICAID? ☐ Yes ☐ No

Name(s): ____________ Date Medicare or Medicaid become effective: ___/___/___

Covered by: ☐ Medicare Part A Only ☐ Medicaid Reason for Medicare or Medicaid coverage: ____________

☐ Medicare Parts A & B

## COBRA

2. Are YOU or any of YOUR DEPENDENTS covered by COBRA? ☐ Yes ☐ No

Name(s): ____________ Date COBRA become effective: ___/___/___

Is/are any COBRA Participant(s) listed disabled? ☐ Yes ☐ No Reason for COBRA coverage: ____________

If yes please describe: ____________

## DISABILITY

3. Are YOU or any of YOUR DEPENDENTS DISABLED? ☐ Yes ☐ No

Name of Disabled Person: ____________

Type of Disability: ____________

Date Disability Began: ___/___/___

Is this person an ☐ Employee or ☐ Dependent

SSD ☐ Yes ☐ No

Medicare ☐ Yes ☐ No

If yes ☐ Part A Only ☐ Parts A & B

Medicaid ☐ Yes ☐ No

## PREGNANCY

4. Are YOU or any of YOUR DEPENDENTS PREGNANT? ☐ Yes ☐ No

Full name of Pregnant Person: ____________ (Please Print)

A. Is this her first child? ☐ Yes ☐ No If no, how were previous babies delivered? ☐ Normal Delivery ☐ Cesarean Section

B. Were any of the previous babies premature? ☐ Yes ☐ No

C. Expected date of delivery? ___/___/___

D. Are there any known complications or has this pregnancy been diagnosed as a multiple birth? ☐ Yes ☐ No If yes, give details: ____________

______________________________

______________________________

## MEDICAL INFORMATION

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that hospitalization, surgery or special tests or treatment is needed or may be necessary in the future? ☐ Yes ☐ No
3. Have YOU or any of YOUR DEPENDENTS had in the past 12 months medical claims in excess of $25,000? ☐ Yes ☐ No
4. Have YOU or any of YOUR DEPENDENTS expect to have medical claims in excess of $25,000 in the next 12 months? ☐ Yes ☐ No
5. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart disease or circulatory condition; cancer or tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below)**; mental/nervous disorder; depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohns disease or intestinal disorder; lupus; lung disease; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? ☐ Yes ☐ No
6. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No

**PROVIDE DETAILS FOR "YES" ANSWERS TO ALL QUESTIONS ABOVE. (Attach a separate sheet of paper if necessary)**

| Question # | Name of individual | Diagnosis | Treatment | Medication | Onset Date | Date(s) of treatment | Hospitalized? (Y/N) | Surgery? (Y/N) | Recovered? (Y/N) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | / / | / / | | | |
| | | | | | / / | / / | | | |
| | | | | | / / | / / | | | |
| | | | | | / / | / / | | | |

I hereby request the coverage for which I and any Dependents are or may become eligible under the employee benefit plan issued by the Employer and authorized the deduction from my earnings of the amount required to cover my share of the costs, if any. If you are declining enrollment for yourself for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. I declare that all statements on this form are complete and true and I understand that they are the basis on which benefits are made available under the plan.

***Employee's Email Address:*** ____________

____________ ____________

*Employee Signature* *Date*