INSURANCE ENROLLMENT FORM

Northwest Missouri State University, 800 University Drive, Maryville MO 64468

EFFECTIVE DATE:

NAME _____ M___F___ MARRIED ____ SINGLE _____

ADDRESS _____ SSN _____

CITY/ST/ZIP _____ 919# _____

PHONE _____ BIRTH DATE _____

JOB TITLE _____ DATE OF HIRE _____

HEALTH INSURANCE: ***Blue Cross Blue Shield of Kansas City***

☐ new enrollee ☐ change enrollment ☐ open enrollment ☐ waive coverage ☐ cancel plan ☐ no change

Plan type: ☐ PPO Base Plan ☐ Qualified High Deductible Plan with H.S.A

Membership type: ☐ Member ☐ Member & Spouse ☐ Member & Child(ren) ☐ Family

☐ ADD ☐ DELETE spouse: _____ m___ f___ SSN:_____ dob: _____

☐ ADD ☐ DELETE child: _____ m___ f___ SSN:_____ dob: _____

☐ ADD ☐ DELETE child: _____ m___ f___ SSN:_____ dob: _____

☐ ADD ☐ DELETE child: _____ m___ f___ SSN:_____ dob: _____

☐ ADD ☐ DELETE child: _____ m___ f___ SSN:_____ dob: _____

DENTAL INSURANCE: ***Delta Dental of Missouri***

☐ new enrollee ☐ change enrollment ☐ open enrollment ☐ waive coverage ☐ cancel plan ☐ no change

Membership type: ☐ Member ☐ Member & Spouse ☐ Member & Child(ren) ☐ Family

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

VISION INSURANCE: ***Ameritas Group Insurance Company***

☐ new enrollee ☐ change enrollment ☐ open enrollment ☐ waive coverage ☐ cancel plan ☐ no change

Plan type: ☐ High/VSP Plan ☐ Low/Reimbursement Plan

Membership type: ☐ Member ☐ Member & Spouse ☐ Member & Child(ren) ☐ Family

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

☐ ADD ☐ DELETE name: _____ m___ f___ relationship:_____ dob: _____

LIFE INSURANCE INSURANCE: ***The Hartford***

Basic Life Insurance is provided by the University at a coverage rate of 1x your annual salary not to exceed $150,000.
Supplemental Life Insurance is available in $10,000 increments not to exceed 5x your annual salary or $450,000.
Enrollment/Changes to your Life Insurance are to be completed on The Hartford Life Insurance Enrollment form.

DEPENDENT LIFE INSURANCE: ***The Hartford***

Dependent Life Insurance on spouse and eligible children is also available in coverage amounts of $10,000/$5,000 or $20,000/$10,000.

LONG TERM DISABILITY INSURANCE: ***The Hartford***

You are automatically enrolled in Long Term Disability Insurance. This benefit is provided by the University.

I authorize my employer to deduct premiums from my paycheck and I certify that all information is correct.

_____ _____

Employee Signature Date

Blue Cross Blue Shield of Kansas City

I request coverage under the Group Contract issued by Blue Cross Blue Shield of Kansas City and Subsidiaries. I authorize my Employer to deduct from my earnings any required contributions. I understand services will be available subject to the exclusions, limitations,and benefits described in the Contract. I understand that if it is determined by Blue KC that a person listed on this application did not meet the Contract's definition of dependent, or I intentionally represented any of the information contained herein; Blue KC and/or it subsidiaries have the right to cancel or rescind coverage for that person or for all persons under the application, and to recover any benefit payments for such ineligible person or persons. I understand no statement I make voids my coverage or reduces my benefits after my coverage has been in force for two (2) years from the effective date, unless my statements are material to the risk assumed and contained in my written application. I understand thatmy medical records will be maintained with strict confidentiality by Blue KC in accordance with applicable federal and state laws. I acknowledge that I have received a Health Benefit Plan Summary that contains information regarding preexisting condition and preexisting condition exclusion periods.

Notice of **Women's Health and Cancer Rights Act**: Along with benefits detailed in your Blue KC Certificate of Coverage and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

Delta Dental of Missouri

I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate issued by Delta Dental Plan of Missouri (DDPM). I authorize the proper deduction, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any dentist or other provider of care to furnish DDPM any necessary information regarding care or treatment of myself or any covered dependents. I understant that courses of dental treatment which began before my effective date may not be covered, and under Coverage C, if included, replacement of bridge or dentures may not be covered during my first year of membership.

Amertias Group Insurance Company

As an employee, I hereby apply or, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFIT PLANS: I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked, and salary information are correct according to the Policyholder's records.