KEY BENEFIT
ADMINISTRATORS

BALL STATE
UNIVERSITY

Benefits Enrollment Form Group Name: ______Ball State University______________________Group #:_____9009_______

Employee Information: Please print clearly using blue or black ink.

Employee Last Name:	First Name:	MI	Date of Birth:

Phone Number:	Email Address:	☐ Male ☐ Female	Social Security #:	BSU ID#:

Street Address:	City:	State:	Zip:

Hire Date:	Department/Work Location:	Department/Work Location Phone #:	Marital Status: ☐Single ☐Married ☐Divorced ☐Surviving Spouse

Please check *one* of the following: ☐ New Employee ☐ Open Enrollment ☐ Qualifying Event/Special Enrollee[1]

[1]Qualifying Event (if applicable): ☐ Loss of Other Coverage ☐ Birth/Adoption ☐ Court Order ☐ Marriage ☐ Divorce ☐Other: _______________________

Date of the Qualifying Event: __________________

If you are declining enrollment for yourself or any dependent(s) because of other coverage, you may in the future be able to enroll yourself or your dependent(s), provided you request enrollment within 30 days after the other coverage ends. 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, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Coverage information: *Please review each Plan Summary Plan Description for important rules and guidelines.*

CHOOSE YOUR HEALTH PLAN:	☐**Enroll**: ☐Myself ☐Spouse ☐Child(ren) ☐Domestic Partner* ☐Other Dependent(s)** *Domestic Partner coverage is only available for same sex domestic partners. The employee and partner must read and sign the Affidavit of Domestic Partner Relationship. **Must be designated as a dependent on your Federal Income Tax Return to qualify for coverage.	Effective Date*: _________________ *The effective date of coverage for a special enrollee, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall be on the date of the Qualifying Event.	**PPO Plan**: ☐Low Deductible PPO (0075) ☐High Deductible Wellness PPO (0077) ☐HSA Qualified HDHP (0079)

Are you or any dependent(s) covered under another **MEDICAL** or **DENTAL** plan? ☐No ☐Yes ☐Yes due to COBRA. If yes, including yes due to COBRA coverage, answer all remaining questions in this section.	Carrier:

Effective Date:	Policy #:	Policy Holder's Name:	Policy Holder's ID #/Medicare HIC#:

Employer:	Covered on Policy: ☐Myself ☐Spouse ☐Children (list names):

Dependent Information: List all dependents below that you are enrolling per the benefits above. Use space on opposite side if needed.

☐Spouse ☐Domestic Partner	Last Name:	First:	MI:	SS#:	DOB:	☐Male ☐Female

Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					

[2]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.
[3]Please note that Social Security numbers are required on all covered dependents. <u>THIS IS A REQUIREMENT UNDER FEDERAL LAW</u>.

Employee Signature: **Sign, date, and return this form to Payroll & Employee Benefits – ADG29 to implement the above enrollment/changes.**

I hereby request coverage under the group policy offered by my employer and I authorize my employer to deduct from my earnings any required contributions. I am an eligible employee working the required hours for my employer. I hereby authorize hospitals, physicians, dentists or other providers of service, including a BSU sponsored wellness program, to furnish Key Benefit Administrators, Inc. or its agents, upon request, any and all reports, records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents together with like reports, records or copies thereof for all earlier services. I further understand that changes to enrollment are generally not permitted during the year, except during a Qualified Open Enrollment Period. However, if I have a change in family status I may make changes such as adding a new spouse or new baby, within 30 days of the event.

Employee: ____ **Employer Approval:** ____
Signature Date Signature Date

Additional Dependent Information:

Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
☐Child ☐Disabled ☐Court ordered[2] **OR** ☐Dependent who ☐ Is designated as a dependent on my Federal Income Tax Return					
Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
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Last Name:	First:	MI:	SS#[3]:	DOB:	☐Male ☐Female
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