OSSEO AREA SCHOOLS
ISD 279

Non EM-O
Health Insurance Enrollment/Change Form

SECTION 1 - EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name	First	MI	Social Security #

Street Address	Phone Number
	( ) -

City	State	Zip Code	Date of Birth	Employee Number
			/ /	

Contract Group:

SECTION 3 - REASON FOR CHANGE

☐ Adding Dependents
☐ Dropping Dependents
☐ Changing Plans
☐ Decline Coverage *(you must complete the additional decline/waiver form)*
☐ Other: ______________________

SECTION 4—NEW PLAN (MEDICAL)

☐ High Plan
☐ Value Plan
☐ HSA Plan

☐ Single
☐ Single + 1
☐ Family
☐ Decline

Effective Date: ______________________________

SECTION 5 - DEPENDENT INFORMATION

Add	Drop	Relationship to Employee	First Name, Middle initial (last name only if different than employee last name)	Gender	Date of Birth (required)	Social Security # (required)

SECTION 5 - EMPLOYEE SIGNATURE

I understand that this election cannot be revoked or changed until the next open enrollment period, unless there is a loss of eligible or life event. The change must be made within 30 days from the date of the life event. (Please contact your Human Resources generalist or refer to the benefits booklet for the life event information.

____
EMPLOYEE SIGNATURE

____
DATE SIGNED

☐ *My spouse is also employed with the district*

For HR use only

Employee Contract Group: ______________________ **Employee Hire Date:** ________________________

TIES: ____________________ **PreferredOne:** ________________ **HRS:** **Audit:**

Updated 6-2015