



FOR EMPLOYER USE

Qualifying Employee Event: New Hire Loss of Other Coverage Gain of Eligibility

Open Enrollment Qualifying Dependent Event: Birth Marriage Loss of Other Coverage Support Order

Effective Date of Benefits: _____ Date of Hire: _____

EE Number: _____ EE Location: _____ Department: _____

*Employer Signature: _____ Date: _____

*Upon signature, the employer indicates that this form has been reviewed and all information is accurate.

ENROLLMENT CHANGE FORM – St. John Neumann School System

Employee Information

Social Security Number		Last Name		First Name		MI
Address				City	State	Zip
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number		Email		

Plan Elections –

	Employee Only	EE + Child	EE + Child(ren)	EE + Spouse	Family	Waiver*
Medical Plans						
Blue Care HMO	<input type="checkbox"/> \$57.05	<input type="checkbox"/> \$250.00	<input type="checkbox"/> \$250.00	<input type="checkbox"/> \$137.10	<input type="checkbox"/> \$250.00	<input type="checkbox"/>
<small>*Reason for Waiving Medical Coverage: _____</small>						
<small>I hereby certify that I and my eligible dependents have been given the opportunity to participate in the group health insurance plan offered by my employer. I understand that in the event that I decide to apply for this coverage at a later date not related to a lifestyle change I and any eligible dependents will have to wait until the annual open enrollment period for enrollment. I understand I may be required to provide proof of other coverage.</small>						
Dental Plan						
Delta Dental	<input type="checkbox"/> \$18.60	<input type="checkbox"/> \$30.45	<input type="checkbox"/> \$30.45	<input type="checkbox"/> \$34.08	<input type="checkbox"/> \$47.42	<input type="checkbox"/>
Vision Plan (Choose One)						
VBA	<input type="checkbox"/> \$4.85	<input type="checkbox"/> \$8.20	<input type="checkbox"/> \$11.40	<input type="checkbox"/> \$8.20	<input type="checkbox"/> \$11.40	<input type="checkbox"/>
Davis Vision	<input type="checkbox"/> \$2.69	<input type="checkbox"/> \$6.99	<input type="checkbox"/> \$6.99	<input type="checkbox"/> \$6.99	<input type="checkbox"/> \$6.99	

Dependent Information

	Name (Last/First/MI)	Gender	Date of Birth	Social Security Number	Medical	Dental	Vision
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive

Please check next page to ensure this form is completed in its entirety.

Primary Care Physician Selection – Required when enrolling in the HMO Plan

A primary care physician (PCP) is a health care professional who practices general medicine. PCPs are the first stop for medical care when enrolled in an HMO plan. Failure to elect a PCP may result in additional out of pocket expenses, therefore a PCP will be assigned if one is not provided. PCPs can be changed at any time by contacting the number on the back of your ID card.

	PCP# (Located on carrier website)	Provider Name (Last/First)	Provider Office Name and Location
Self			
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			

Spending Accounts Options

	Per Pay Contribution	Annual Contribution
Flexible Spending Account (FSA)	\$	Up to \$3,050
Dependent Care Account (DCA)	\$	Up to \$5,000

Employee Signature

Please note that all deductions will be taken on a pre-tax basis unless otherwise instructed. I understand that I cannot change or revoke my election as of any date prior to the next open enrollment period unless I notify my Human Resources office within 30 days of a qualified change in status. The information provided above is true and correct to the best of my knowledge and I accept the provisions that I have read and understood.

Employee Signature _____ Date _____



Ellis Preserve Office | 3809 West Chester Pike, Suite 190 | Newtown Square, PA 19073
 Kingston Office | 31 North Gates Avenue | Kingston, PA 18704

If you have any questions about completing this form, please call Creative Benefits, Inc.'s ESR team or your HR Department.
 ESR Team: 1-844-231-8414 | esr@creativebenefitsinc.com