BI·STATE DEVELOPMENT

ACTIVE MEDICAL, DENTAL & VISION ENROLLMENT/CHANGE FORM

PLEASE PRINT

A QUALIFYING EVENT

☐ NEW HIRE ☐ DIVORCE/LEGAL SEPARATION ☐ BIRTH/ADOPTION OF A CHILD ☐ OPEN ENROLLMENT

☐ MARRIAGE ☐ DEATH OF SPOUSE/CHILD ☐ DEPENDENT GAIN/LOSE OTHER COVERAGE ☐ CHILD AGE OUT

☐ OTHER ____________________

DATE OF HIRE/QUALIFYING EVENT (MM/DD/CCYY)

B

EMPLOYEE LAST NAME	FIRST NAME	MI	EMPLOYEE SOCIAL SECURITY NO.
			___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	CELL PHONE	EMPLOYEE BADGE NO.
	( )	( )	

STREET ADDRESS	CITY	STATE	ZIP CODE

☐ **New address and/or phone #**

If checked, BSD system will be updated

C **LIST ALL DEPENDENTS YOU WISH TO ADD OR REMOVE FROM COVERAGE: ***NO CHANGES WILL BE MADE TO DEPENDENTS NOT LISTED BELOW*****

	MEDICAL/ RX	DENTAL	VISION	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO. ### - ## - ####	DATE OF BIRTH MM/DD/CCYY	
SPOUSE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	☐ M ☐ F
CHILD	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	☐ M ☐ F
CHILD	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	☐ M ☐ F
CHILD	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	☐ M ☐ F
CHILD	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE	☐ ADD ☐ REMOVE				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	☐ M ☐ F

D

MEDICAL PLAN: ☐ Premium ☐ Preferred ☐ Economy ☐ Opt Out of Coverage

☐ HDHP + **Annual** Vol HSA Contribution $___________.00 /year (Min $0 -- Max $3,150 Single, $6,300 Family, Over 55 $1,000 Catch-up Contribution)

DENTAL PLAN: ☐ High ☐ Low ☐ Opt Out of Coverage

VISION PLAN: ☐ Standard Coverage ☐ Opt Out of Coverage

NOTE: DEPENDENTS CANNOT BE ADDED WITHOUT A **VALID SOCIAL SECURITY NUMBER** AND A **COPY OF A MARRIAGE LICENSE (SPOUSE)** OR **BIRTH CERTIFICATE (CHILD)**

E **SIGNATURE** – The information provided above is true and correct to the best of my knowledge, and **I accept the provisions on the reverse side of this form which I have read and understand.**

EMPLOYEE'S SIGNATURE	PRINT EMPLOYEE NAME	DATE

PLEASE READ THE REVERSE SIDE BEFORE SIGNING

Please read the following carefully.

1. I hereby request coverage as specified and authorize any current and missed deductions from my compensation for my portion of the cost of the benefits.
2. In order to enroll a dependent spouse or a dependent child in the medical, dental and/or vision plan, Bi-State Development requires a marriage license for the dependent spouse and a birth certificate for the dependent child.
   Note – The Birth Certificate must show the Bi-State Development employee as one of the parents, if employee's name is not on the birth certificate, it is not considered to be acceptable documentation. In the case of a stepchild, along with a birth certificate, please also submit a marriage license that shows the name of the parent that is listed on the birth certificate.
3. I understand that misrepresentation in completing this form, or non-payment of my share of the premium, may result in cancellation of coverage.
4. In the event that my health coverage would be terminated due to non-payment of my portion of the costs, I authorize deductions from any future compensation for my portion of the cost of benefits. This repayment will begin with my first available paycheck and my past non-paid portion of the benefit costs, will be deducted according to the current year's premium schedule.
5. I understand that it is my responsibility to report to the Plan any change in the eligibility of my dependents.
6. Per IRS guidelines, this enrollment form and supporting documentation must be received by HR-Benefits within 31 days of your hire date or the date of the qualifying event for changes to be made outside of the yearly open enrollment.
7. Return completed form to: Bi-State Development/HR Benefits, Mailstop 125, 211 North Broadway, Suite 700, St. Louis, MO 63102