Election of Participation

If your authority is interested in enrolling in any of our insurance programs, you must complete this form and return it to our office.

We will need enrollment forms for each individual to be enrolled. Please keep in mind that all the enrollment forms must be in our office before we can establish an effective date.

Please indicate the plans you wish to be enrolled in:

MEDICAL INSURANCE PLANS:

__PPO Plan 2
__PPO Plan 3
__PPO Plan 5
__PPO Plan 6
__PPO Plan 7

MEDICARE ADVANTAGE PLANS:

__PPO Plan w/Rx 1203
__PPO Plan w/Rx 1338
__ESA Plan w/Rx 1203
__ESA Plan w/Rx 1338

__Number of Enrollment Packets Needed

SHORT TERM DISABILITY PLANS:

__Plan 1
__Plan 2
__Plan 3

DENTAL INSURANCE PLANS

__Plan #1
__Plan #2

VISION INSURANCE PLANS:

__Employer Paid
__Voluntary

_____Number of Enrollment Forms Needed

LIFE INSURANCE PLANS

__Plan $10,000
__Plan $25,000
__Plan $50,000
__Plan $75,000

AUTHORITY & COUNTY_____
AUTHORITY SECRETARY_____
ADDRESS _____
_____
TELEPHONE NUMBER _____
FAX NUMBER _____
EMAIL ADDRESS _____
PROBATIONARY PERIOD: Y OR N # OF DAYS:
(Cannot exceed 90 days for a medical plan) _____

SIGNATURE: _____
DATE: _____
TIN #: _____

PSATS Trustees Insurance and Retirement Services