



PSATS TRUSTEES INSURANCE AND RETIREMENT SERVICES

Enrollment Form

Please print legibly and complete this form in its entirety.

Blank fields will cause significant delays in processing.

Entity Name

(This is the Township, Municipality or Authority name)

Grid for Entity Name

County

Grid for County

Employee First Name

Grid for Employee First Name

M.I

Grid for M.I

Last Name

Grid for Last Name

Employee Email Address

Grid for Employee Email Address

Occupation

Grid for Occupation

Non-Working Supervisor

Employee Street Address

Grid for Employee Street Address

City

Grid for City

State

Grid for State

Zip Code

Grid for Zip Code

Date of Birth (mm/dd/yyyy)

Grid for Date of Birth

Employee Social Security Number

Grid for Employee Social Security Number

Gender

Grid for Gender (M, F)

Fulltime Start or Rehire Date

Grid for Fulltime Start or Rehire Date

The Fulltime Start or Rehire Date is the employee's first day of work or date rehired into an eligible status (i.e. return from layoff within 90 days).

Individuals Covered – List individuals for whom you are adding/changing/removing coverage

Table with columns: Coverage Type, First Name, Middle Name, Last Name, Relationship, Sex, Birthdate, Social Security #, College Student (Y/N)

COVERAGE Type Codes: Your employer will inform you of available coverage.

Medical - M Dental - D Vision - V Vision Grp No. 4115 Life/AD&D - L PSATS will complete the above numbers

Short Term Disability, Plan # (1,2,3), Annual Salary, Weeks Worked Per Year, Hours Worked Per Week

Beneficiary Information: Must be completed for anyone enrolling in life insurance.

Table with columns: Name (last name, first, middle initial), Relation to You, Benefit %

Internal PSATS use only

PSATS ID #, Member ID #, Effective Date

**Declining coverage – Check all that apply.**

This section must be completed if the employee is not enrolling for even just one product offered by the employer or if any of their dependents are not enrolling in eligible products. It is NOT necessary to waive products not offered by the employer.

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:			
<input type="checkbox"/> Employee:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	Reason for declining coverage <input type="checkbox"/> Insurance through another job
	<input type="checkbox"/> Med Advantage	<input type="checkbox"/> Vision	<input type="checkbox"/> Parental group coverage <input type="checkbox"/> TRICARE/Military coverage
	<input type="checkbox"/> Life/AD&D	<input type="checkbox"/> ST Disability	<input type="checkbox"/> Spouse/domestic partner group coverage <input type="checkbox"/> Individual coverage – On Exchange
<input type="checkbox"/> Spouse/ domestic partner:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Medicare <input type="checkbox"/> Individual coverage – Off Exchange
	<input type="checkbox"/> Med Advantage	<input type="checkbox"/> Vision	<input type="checkbox"/> Medicaid <input type="checkbox"/> Another group plan provided by my employer
<input type="checkbox"/> Children:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Retiree coverage <input type="checkbox"/> Do not want
	<input type="checkbox"/> Med Advantage	<input type="checkbox"/> Vision	<input type="checkbox"/> COBRA coverage <input type="checkbox"/> Other _____
<b>I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.</b>			
Please sign here ONLY if you are declining coverage for yourself and/or dependents. Must be signed if employee or dependents are waiving any of the offered products.			<b>Date (Month/Day/Year)</b>
<input type="checkbox"/> I am declining coverage. Employee signature: X			
<b>Please PRINT employee name:</b>			

**Request for Signature and Certification:** I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.  
**Signature required if enrolling in any product.**

\_\_\_\_\_  
Employee Signature                      Date                      Work Phone                      Home Phone

**RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYEE**

Employer Signature \_\_\_\_\_ Date: \_\_\_\_\_

Employer signature required on all enrolling or waiving forms.