Employee Enrollment Initial Group	t / Change ☐ COBRA	A 🔲 Open Enr	ollment				
☐ New Employee		e (complete changes ect on reverse side)	ion				
EMPLOYER NAME City of Logansport	GROUP N 76-4138	NUMBER	EMPLOYEE	START	DATE	EFFEC	TIVE DATE
EMPLOYEE Public Safety Employees		d Officials ☐ All Othe	r Employees (C	Civil City	Do you	use any	forms of Nicotine?
EMPLOYEE JOB LOCATION MAYOR CLERK-TREASURER BUILDING/CODE		☐ PLANNING ☐ STREET ☐ POLICE		<u>[</u>	☐ FIRE ☐ CEMETI ☐ PARKS ☐ GOLF		
SOCIAL SECURITY NUMBER							-
NAME: LAST		FIR	ST			M.I.	
ADDRESS		CITY	STATE	Z	ZIP		EMAIL ADDRESS
DATE OF BIRTH / /	GENDER			HOME	TELEPHO	NE NUM	IBER
				<u> </u>			
Do you or any family member c If yes to the above question, con Employer Name	currently have mplete the fol	e other health coverage? llowing: Person's nam Carrier Name	ne	ingle		amily Plan Num	□ No lber
If yes to the above question, con	currently have implete the fol	llowing: Person's nam	ne	ingle		Plan Num	
If yes to the above question, con Employer Name	emplete the foll	llowing: Person's nam Carrier Name	spouse	ingle	Dental P	Plan Num Plan loyee loyee plu	
If yes to the above question, con Employer Name Medical Plan Employee Employee plus spouse Employee plus child/child	emplete the foll	Vision Plan Employee Employee plus	spouse	ingle	Dental P Empl	Plan Num Plan Plan loyee loyee plu loyee plu loyee plu	us spouse
If yes to the above question, con Employer Name Medical Plan Employee Employee plus spouse Employee plus child/child Family Waive MPLETE THIS SECTION IF EL	dren	Vision Plan Employee Employee plus of	spouse child/children	ingle	Dental P Emp Emp Emp	Plan Num Plan Plan loyee loyee plu loyee plu loyee plu	us spouse
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If yes to the above question, con Employer Name	LECTING DE SS#	Vision Plan Employee Employee plus Empl	spouse child/children GE DATE GE	NDER M F	Dental P Empl Empl Fami	Plan Num Plan loyee loyee pla loyee	us spouse us child/children

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

(COMPLETE THIS SECTION IF MAKING CHANGES.
	Effective date of change: Pleases pecify change and update in appropriate section.
	☐ Employee name change
	Employee address change
	☐ Job location change
	☐ Job title change
	☐ Earnings change
	Return to work
	Other coverage change
	Date of marriage
	Li Date of Divorce
	☐ Eligible for Medicaid/CHIP subsidy
	Loss of Eligibility for Medicaid/CHIP subsidy
	│ LJ Add dependents
	Remove dependents (list names) Reason:
	I LI Aud coverage
	☐ Voluntarily Terminate coverage (Indicate which coverages)
	☐ State/Federal Continuation
	Employee Signature Required
	Employment termination: Reason:Last day workedDate coverage terminated
	Last day workedDate coverage terminated
	WAIVING COVERAGE
	Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in
	this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPA A Special Enrollment because of large files.
	under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:
	I attest that I am declining group health coverage because I am currently enrolled in other group health or incurrence
	1 of specific plan language contact your Human Resources Representative
	CERTIFICATION: I freely and voluntarily waive all coverage noted above.
	EMPLOYEE SIGNATURE DATE
- 1	
T L	oroby and Grahat II and I are a second
TH	pereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions
	sman's engionity for coverage have been sausfactorily resolved.
1 u	inders tand that I may not change the coverage elections that I make on the Employee Enrollment/Change Formuntil the plan's next
٠P	amount of officer of the source of the
PR	ease refer to your Employee Benefit Booklet for specific details of your benefit plan.
Ш	I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for
	coverage.
	EMPLOYEE SIGNATURE DATE

DATE