

**INDIANA STATE UNIVERSITY
STAFF BENEFITS ADMINISTRATION**

**APPLICATION FOR LATE ENROLLMENT
HEALTH, DENTAL AND PRESCRIPTION DRUG CARD COVERAGE**

Employee Name _____ Employee ID# _____

Employee Address _____

This request is for the following people to be added to coverage:

Name	Social Security Number	Date of Birth	Relationship to Employee	Effective Date

Late enrollment is due to the following event:

- Termination of coverage under another employer's health plan due to the employer terminating the plan.
Date of termination _____. (Please attach documentation showing when coverage was terminated, who was on the coverage and why the coverage was terminated)
- Termination of coverage under another employer's health plan due to termination of employment or reduction of hours.
(Please attach documentation showing when coverage was terminated, who was on the coverage and why the coverage was terminated)
- Loss of coverage under another health plan due to divorce or separation. (Please attach documentation showing who was on the other coverage, when the coverage was terminated and a copy of the divorce papers showing the effective date of the divorce.)
- Loss of coverage under another employer's health plan due to death of the employee with the other coverage. (Please submit a copy of the death certificate of the employee, and documentation showing who was on the other coverage and when the other coverage terminated)
- Loss of coverage due to disqualification from a state or federally sponsored health plan.

CONDITIONS OF COVERAGE

I understand that one of the above events must have occurred in order for me to be eligible for late enrollment. I have indicated above which event has occurred. I also understand that I must apply for coverage within 31 days of the above event and I will provide documentation within the first 90 days or I will forfeit my right to late enrollment.

Signature _____ Date _____

ACCEPTANCE OF COVERAGE

I wish to apply for coverage in the ISU group health, dental and prescription drug card program. I assign all payments as specified in the contract. I authorize persons who provide me or my dependent's health care to furnish Indiana State University or its plan administrators with whatever information or records they may need to determine medical risk classifications or liability under this contract. I also authorize Indiana State University or its plan administrators to exchange with other organizations whatever information concerning me or my dependents' health care expenses each party may need to determine its share of the liability. In recognition of the legitimate interest of the contractholders in reviewing historical data setting forth the volume, nature and cost of health care service paid by Indiana State University or its plan administrators for which I am applying for coverage. I hereby authorize Indiana State University or its plan administrators to provide the contractholders with the information relating to medical services and treatment rendered to me and / or dependents listed on the application, except as otherwise provided by law. I understand that my coverage will begin as of the date of the above qualifying event. I also understand that a claim of mine may be denied or my coverage canceled if it is determined that I gave material false information on this application or with a claim for payment.

Signature _____ Date _____

DEDUCTION AUTHORIZATION

I Hereby Authorize Indiana State University, until termination of my employment or until this authorization be revoked by notice in writing, to deduct in advance each month from any earnings or accrued pay due me the amount required for my coverage and to remit same to Indiana State University or its health administrator. I understand that the coverage fees shall be set forth in the current premium schedule of ISU health, dental and prescription drug card plan and posted or distributed on the campus of Indiana State University.

Signature _____ Date _____

INDIANA STATE UNIVERSITY -- STAFF BENEFITS ADMINISTRATION
ISU Health Plan Salary Conversion Program Option Election Form

NAME _____ DEPT _____

SSN _____ EFFECTIVE DATE _____ MONTHLY _____ BI-WEEKLY _____

Indiana State University offers a Salary Conversion Program, under Section 125 of the Internal Revenue Code, which allows employees to use pre-tax dollars to pay their Health Plan contributions, thereby eliminating state and federal income taxes and reducing Social Security (FICA) taxes by your amount of the Health plan contribution. As an employee participating in the Health Plan, you may elect to participate in the Salary Conversion Program. Each calendar year, you have the opportunity to evaluate your previous decision and make a change by completing a new form, if you so desire. If you have coverage including a same-sex domestic partner, and you chose "Reduct", only the employee portion will be taken before taxes and the rest of the contributions will be deducted after taxes are applied. Section 125 does not allow reduction for contributions for domestic partner coverage.

Please check the appropriate option below:

OPTION 1: _____ (REDUCT - BEFORE TAXES) I elect to participate in the Salary Conversion Program.

I understand that this election will remain in force for the entire calendar year unless a change in family status occurs (marriage, divorce, death, birth or over age dependent) and I complete a new election form. If I decide to change it for the following calendar year I must complete and return this form by the deadline each December.

I understand that by electing to participate, state/federal income taxes as well as Social Security (FICA) taxes will be eliminated for the amount of the Health plan contribution that I pay and this may increase my take-home pay. Along with a reduction in state/federal taxes, this may also reduce my Social Security income at retirement if my salary is below the 2006 Social Security Wage Base (\$94,200).

Signature of Employee

Date

OPTION 2: _____ (DEDUCT - AFTER TAXES) I elect NOT to participate in the Salary Conversion Program.

I understand that this election will remain in force for the entire calendar year unless a change in family status occurs (marriage, divorce, death, birth or over age dependent) and I complete a new election form. If I decide to change it for the following calendar year I must complete and return this form by the deadline each December.

Signature of Employee

Date