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MIDWEST AREA SCHOOL EMPLOYEES' INSURANCE TRUST

☐ New Enrollment ☐ Change ☐ Annual Plan Election

The Midwest Area School Employees' Insurance Trust is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.

PLEASE PRINT

EMPLOYER INFORMATION

School Corporation: ***Pioneer Regional School Corporation*** No. of Hours to be Worked Per Week_____

Date of Hire_____ Position_____

EMPLOYEE INFORMATION

Last Name	First	Middle	Date of Birth	Social Security Number

Home Address ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Home Phone ( )

City State Zip Code

COVERAGE SELECTION

Choose one Plan option for the calendar year. If you have family coverage, you and all of your dependents must enroll in the same Plan.

MEDICAL	☐ Single	☐ Family	☐	☐	Effective Date_____
Active	☐ PPO 1	☐ PPO HSA 2	☐ PPO 3	☐	
Retiree Coverage	☐ PPO 1	☐ PPO HSA 2	☐ PPO 3	☐	
COBRA	☐ PPO 1	☐ PPO HSA 2	☐ PPO 3	☐	

LIFE (64274) ☐ Yes ☐ No Effective Date:_____ Amount of Coverage 50,000

Name of Primary Beneficiary Relationship

Date of Birth Social Security Number

Name of Secondary Beneficiary Relationship

Date of Birth Social Security Number

LTD (64274) ☐ Yes ☐ No Effective Date:_____ Monthly Earnings $_____

Name of Beneficiary (If Different) Relationship

Date of Birth Social Security Number

IF YOU ARE ENROLLING ELIGIBLE DEPENDENTS, COMPLETE THE FOLLOWING SECTION

SPOUSE INFORMATION

Last Name	First	Middle	Date of Birth	Social Security Number

Spouse's Employer Name Primary Care Physician (Name or Number)

DEPENDENT CHILD(REN) INFORMATION

(Must be an unmarried natural blood related child, step-child, child placed with the employee in anticipation of adoption, legally adopted child or child for which the employee has legal guardianship whose age is less than 23. Also includes a child younger than 23 who is entitled to coverage because of a qualified medical child support order).

First Name (Last if Different)	Provide over half of child's support or claim as federal tax dependent?	Court Ordered Coverage Required?	Does Child Have Other Insurance (Y/N)	Sex (M/F)	Is Your Child Over the Age of 23? (Y/N)	Date of Birth	Social Security Number	HMO Primary Care Physician (Name or Number)

Other Group Coverage Including Medicare

If other coverage is provided for you or any family member for Medical, please provide details below. If additional space is needed, attach a separate sheet of paper.

Name of Family Member and Relationship	DOB	Name of Insurance Carrier	Group Number

ACCEPTANCE

1. I hereby request the amount(s) and form(s) of coverage for which I am eligible under the plans of my employer and I authorize same to deduct the required contribution from my earnings. I understand that I have the right to revoke this deduction authorization by written request, subject to Section 125 rules, if applicable. I hereby knowingly and freely waive my eligibility for types of coverage checked in the **REFUSAL** section.

2. I hereby certify that the dependents listed are my dependents as defined in the benefit plan. I agree to notify my employer of any change in status of any dependent, or of any additional dependents I may acquire.

3. As a condition to receiving benefits under the Trust, I agree to transfer to the Trust my right to make claim, sue and recover from any person or business entity any funds paid or payable as a result of personal injury or reimbursement for covered expenses. Alternatively, if I receive any recovery, by way of judgment, settlement or otherwise, from another person or business entity, I will reimburse the Trust in full, in first priortiy, for any covered expenses paid by it. I understand and agree that this right of subrogation and/or reimbursement shall also apply with respect to any of my dependents covered under the Trust. I agree to cooperate fully with the Trust and shall provide any information requested by the Trust within five (5) days of the request.

4. I hereby represent and agree that all the answers and statements on this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements could result in denial of an otherwise valid claim and voiding or reparations of insurance.

Signature of patient/employee _____ Date _____

REFUSAL OF COVERAGE

☐ **I would like to waive coverage under the Trust. You must sign the below.**

If you are declining coverage, are you covered under another health plan? ☐ Yes ☐ No

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty days after the marriage, birth, adoption, or placement for adoption.

I have decided **not** to apply for coverage for: MEDICAL ☐ Self ☐ Dependent ☐ LIFE ☐ LTD

SIGNATURE _____ DATE _____

SIGNATURE OF AUTHORIZED PERSONNEL _____ DATE _____

PLEASE RETURN TO YOUR SCHOOL CORPORATON TREASURER

Enrollment Application

Anthem

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through **www.anthem.com.**

1. Employer Use: Employer Name and Address:	Pioneer Regional School Corporation/ MASE Trust PO Box 577 Royal Center IN 46978					
Group #	Sub-group #		Request. Effective Date	Applicant #/Dept. name		
00110735			/ /			
Anthem use: Plan	Health Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	/ /

2. Reason for Application

☐ New enrollment ☐ New hire
☐ Waiver ☐ Rehire (date) ___/___/___
☐ Annual open enrollment ☐ Add dependent (see section 3)
☐ COBRA
☐ Conversion
Qualifying event _____ Event date ___/___/___

3. Status Change/Event

Event date ___/___/___ ☐ Adoption*
☐ Marriage ☐ Legal guardianship*
☐ Birth ☐ Other_____
Include legal documentation.

4. Type of Coverage/Plan

Health Coverage (Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.)	*Dental Coverage*	*Vision Coverage*
☐ HMO* (not applicable to Ohio) ☐ Blue Traditional® ☐ POS ☐ PPO ☐ EPO (Ohio only) ☐ Lumenos, Health Savings Account ☐ Lumenos, Health Reimbursement Account ☐ Lumenos, Health Incentive Account ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	☐ PPO ☐ Traditional (Indiana and Ohio only) ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	☐ Vision ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage

5. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth / /	Age	Sex ☐ M ☐ F	Social Security # (SS# required for Lumenos, Health Savings Accounts) - -	☐ Single ☐ Divorced ☐ Married

Home address	City	State	Zip code	County (KY residents include Municipality)
Home telephone ( ) -	Business telephone ( ) -		eMail Address	

Are you: Retired? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2 ☐ 1099 ☐ Other: _____

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

6. Family Information *Spouse and dependents to be enrolled. (Attach a separate sheet if necessary.) *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

1 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

2 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

3 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

4 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

7. Other Health Coverage *Please check one:* ☐ *YES (completed below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant	

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID#	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	

Reason for Medicare entitlement:
☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

8. Prior Health Coverage *Please check one:* ☐ *YES (completed below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	Dates policy in effect: / / — / /

Please check the type of prior coverage
☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") administers the HMO and POS policies.

Thank you for choosing Anthem Blue Cross and Blue Shield.

9. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date / /

Please complete the waiver on the next page if you and / or any eligible dependent are not enrolling.

10. Waiver of coverage for employee and / or any eligible dependent not enrolling

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group benefit booklet, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

Applicant Signature	Date / /