

Please select and read the instructions below that apply to the changes you are making:

You may complete the form either by typing directly onto the form (use your TAB key to navigate) or just print off and handwrite your choices.

To Enroll:

1. Complete sections:
 - A. Employee Information
 - B. Dependent Information
 - C. Membership choices: Select the coverage you wish to enroll, i.e. health/dental choice, single/family.
 - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
 - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

To Drop Coverage:

1. Complete sections:
 - A. Employee Information
 - C. Check Terminate Coverage box(es). Print and sign the waiver line.
2. Mail or bring the form to the Office of Human Resources.

To Change Status of your Coverage:

1. Complete sections:
 - A. Employee Information
 - B. Dependent Information
 - C. Membership Choices: Select the coverage you wish to change to, i.e. health/dental choice, single/family.
 - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
 - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

PART A – EMPLOYEE INFORMATION

Employee's Name	Last	First	M.I.	Social Security Number
Employee's Home Address	Address		City	State
	Day Phone Number (w/ area code) ()		Evening Phone Number (w/ area code) ()	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Date of Birth (M / D / Y)

PART B – DEPENDENT INFORMATION

Relationship to Employee	First	M.I.	Last (if different from employee)	Social Security Number	New Dependent	Gender (M/F)	Date of Birth M/D/Y	Over Age 19 & Full Time Student
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Dependent children age 19 to 25 must be full-time students to be covered by Concordia College's medical/dental plan. These dependents would not qualify for the Ortho portion; this coverage is for dependents through the age of 18. If the dependent's last name is different from your own, please attach explanation.

PART C – YOUR MEMBERSHIP CHOICES

Health Insurance (Blue Cross & Blue Shield of MN) <input type="checkbox"/> Elect: ___ Single ___ Family <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Waive	Dental Insurance (Delta Dental of MN) <input type="checkbox"/> Elect: Standard Plan ___ Single ___ Family <input type="checkbox"/> Elect: Standard + Ortho ___ Family only <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Waive
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Benefit Waiver (sign ONLY if declining coverage). I understand that by waiving coverage for myself and/or my dependents I cannot elect to participate until next year unless I experience a status change in accordance with the IRS section 125 and submit the change within 30 days of the status change. BCBSMN & Delta Dental reserve the right to decline any further enrollment changes.

Employee Signature: _____ Date: _____

PART D – OTHER INSURANCE/MEDICARE COVERAGE (If does not apply skip to PART E)

Dental Do you (employee) have any other dental coverage? <input type="checkbox"/> Yes Do your dependants have other dental coverage? <input type="checkbox"/> Yes	Name of Insurance Co: _____ Name of Individual with Coverage: _____ Policy/ID No: _____
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Health
Do you or any family member applying for coverage currently have other medical coverage or Medicare? (please complete the following)
Name of Insurance Co: _____ Name of the individual with Coverage: _____
Policy/ID No.: _____

PART E – AUTHORIZATION OF COVERAGE

I hereby enroll for coverage. I authorize my employer to deduct my premiums before taxes are calculated (premium conversion). Employees will automatically be enrolled in this portion of the Section 125 plan. I understand that I cannot make change or revoke my election for one plan year unless I experience a status change in accordance with the IRS Section 125 and submit the change within 30 days of the status change. You may opt out of the before tax deduction by checking here: By checking this box, I am requesting after tax deductions.

Employee Signature _____ Date _____

GROUP ENROLLMENT INFORMATION – THIS PORTION TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Hire Start Date _____ Effective Date _____	<input type="checkbox"/> Qualifying Event <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change in employment status <input type="checkbox"/> Termination/Voluntary Resignation <input type="checkbox"/> Other (Details) _____	Date Event Occurred: _____ Effective Date of Coverage: _____ End Coverage Effective: _____
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Group Name Concordia College Office of Human Resources, 901 8th St S, Moorhead, MN 56562
BCBSMN Group: EP606-W0
Delta Dental MN Group: 50814

Group Representative's Signature _____ **Date:** _____ **Phone Number:** (218) 299-3339