SISCO

SECTION I – EMPLOYEE INFORMATION AND COVERAGE ELECTION

Employer Name **University of Dubuque**	Group # **012**	Payroll Cycle	Division	Circle Plan **A B C**

Name (First, MI, Last)	Social Security #_____-____-_____	Hire Date____/____/____
Street Address	**Telephone**	**Effective Date**____/____/____
City **State** **Zip**	**Date of Birth**____/____/____	**Email address**

❑ **Male** ❑ **Female** **Marital Status** ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Legally Separated** ❑ **Widow/Widower**

Medical	**Dental**	**Vision**	**Reason for Completing this Form**	
❑ **Single**	❑ **Single**	❑ **Single**	❑ **New Hire**	❑ **Part/Full-time Change**
❑ **EE/Spouse**	❑ **EE/Spouse**	❑ **EE/Spouse**	❑ **Late Enrollment**	❑ **Special Enrollment/Loss of Coverage**
❑ **EE/1child**	❑ **EE/1 child**	❑ **EE/1child**	❑ **Marriage/Birth/Adoption**	**Date Coverage lost** _____
❑ **Family**	❑ **Family**	❑ **Family**	❑ **Terminate Coverage for one/all dependents**	❑**Voluntary or** ❑ **Lost other coverage**
❑ **Decline**	❑ **Decline**	❑ **Decline**	**List dependents who are no Longer covered** _____	**Date of Event/Change** ____/____/____

SECTION II – ELIGIBLE DEPENDENTS INFORMATION **Note: This application does not guarantee coverage.**

Name (First, MI, Last)	Relationship	Social Security # - (SSN) *Federal law MMSEA requires collection of SSN for all dependents*	Date Of Birth	Gender	DEPENDENTS OVER AGE 19
Spouse	❑ Spouse (lawful) ❑ Common Law *if plan allows ❑ Other			❑ **M** ❑ **F**	I have reviewed the dependent eligibility terms of the plan and the dependents listed below are eligible for coverage. I will advise my health plan of any changes that will affect their coverage. **Signature**_____ **Date** _
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ **M** ❑ **F**	

SECTION III – OTHER COVERAGE Note: This section must be completed for SISCO to process your dependent claims.

PART A: Spouse (if applicable) **Date of Marriage**

Name & City of Employer

_____

Does your spouse have other coverage with this employer?
☐ Yes ☐ No

If no, is he/she eligible for other coverage with this employer?
☐ Yes ☐ No

If your spouse does have other coverage through this employer,
1. Indicate the type of coverage:
   ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan _____
   _____

PART B: Ex-spouse (if applicable) **Divorce Date**

(*this information is for Coordination of Benefits for any dependent children)*
Ex-Spouse Name(s)_____
Address(es)

Social Security # (*if available*)_____

Name and City of Employer(s)

_____

If your ex-spouse has coverage through this employer,
1. Indicate the type of coverage:
   ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan_____

Does your spouse or any other dependents have Medicare? ❑ **Yes If yes, who?**_____ ❑ **No**
Are your spouse or any dependents disabled? ❑ **Yes If yes, who?** ❑ **No**

SECTION IV – SIGNATURE TO ELECT OR DECLINE COVERAGE

Elect: *The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings (pre-tax if applicable). I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments, this auth will be used for verification of benefit eligibility and claim processing. This consent is subject to revocation at any time through a written submission to SISCO.*

Decline: *I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.*

❑ *I do have other coverage*
❑ *I do not currently have other coverage*

Signature	**Date**	**Signature**	**Date**