

WEA Trust – Enrollment Form

PLEASE USE BLACK OR BLUE INK TO COMPLETE THIS FORM!

EMPLOYEE INFORMATION

Complete This Section In Its Entirety!

First Name	MI	Last Name	Suffix (e.g., JR, III)
Street Address			
P.O. Box (if any)	City		
State	Zip Code	Date of Birth	Social Security Number
Telephone Number		Gender	Are you totally disabled, on sick leave, on medical leave, retired, or on COBRA? <input type="radio"/> NO <input type="radio"/> YES If YES, which one applies? _____

EMPLOYMENT INFORMATION

Please complete your school district name and group number. Please complete the remainder of this section if you are a new applicant applying for coverage or if you are reporting a change in your occupation or the hours you work.

School District / Employer Name			
WEA Trust Group Number	Date of Employment	Annual Salary	Average hours worked/week

SELECT THE ONE OCCUPATION THAT MOST CLOSELY MATCHES YOURS

<input type="radio"/> Teacher	<input type="radio"/> Administrative Secretary	<input type="radio"/> Cook/Food Service	<input type="radio"/> Audio/Visual Technician
<input type="radio"/> Administrator	<input type="radio"/> Secretary/Clerical	<input type="radio"/> Transportation Director	<input type="radio"/> Nurse/Therapist
<input type="radio"/> Business Manager	<input type="radio"/> Custodial/Maintenance	<input type="radio"/> Mechanic	<input type="radio"/> Counselor
<input type="radio"/> Bookkeeper/Payroll	<input type="radio"/> Building & Grounds Supervisor	<input type="radio"/> Bus Driver	<input type="radio"/> Psychologist/Psychiatrist
<input type="radio"/> Library/Teacher Aide	<input type="radio"/> Food Service Supervisor	<input type="radio"/> Librarian	<input type="radio"/> Other: _____

My position is considered a 9-, 10-, or 12-month position

Health, dental, long term disability, long term care, and life insurance are underwritten by WEA Insurance Corporation.

Enter Employee Social Security Number _____

TELL US WHY YOU ARE COMPLETING THIS FORM (choose one event)

- I am a new employee or have been rehired.
- I lost other group coverage.
- I am taking advantage of a group open enrollment.
- I am a late applicant.
- I returned from a leave.
- I am taking advantage of an annual dual choice enrollment.
- I have married and want to add my spouse and/or dependents.
- I am transferring to the Alternate Benefit Program.
- I have the same occupation but am working different hours now. I was working . hours per week.
- I have divorced.
- I changed occupations.
- I am completing this enrollment form to change my beneficiary information.
- I am enrolling for a reason other than those listed above. Reason: _____

TELL US THE DATE THE EVENT THAT YOU INDICATED OCCURRED.

- -

mo day year

TELL US WHAT INSURANCE COVERAGE YOU ARE ENROLLING IN

Complete this section if you are applying for or waiving insurance coverage. To determine which plans you are eligible to apply for, contact your school business office or call WEA Trust. To apply for the insurance plans listed below, darken the circle that corresponds to the plan. If you apply for health, drug, dental, or long term care coverage, you must indicate family or single coverage. If you do not wish to enroll, darken the appropriate circle and initial the space provided.

HEALTH (choose only one plan type)

- Corridor Deductible
- Front-End Deductible
- Point of Service (POS)
Network Designation _____
(List network only if instructed.)
- Preferred Provider Plan

(choose only one) Single Family

If you do not wish to enroll; fill the circle and initial next to the appropriate statement

- I am waiving because I have other coverage ____
- I am waiving to take an alternative benefit ____
- I am waiving, I have NO other coverage or alternative benefit available ____

DENTAL

Single Family

FILL CIRCLE AND INITIAL LINE IF YOU DO NOT ENROLL. ____

LONG TERM DISABILITY (LTD)

Self

FILL CIRCLE AND INITIAL LINE IF YOU DO NOT ENROLL. ____

LONG TERM CARE (LTC)

Self Self & Spouse

FILL CIRCLE AND INITIAL LINE IF YOU DO NOT ENROLL. ____

LIFE

Self

FILL CIRCLE AND INITIAL LINE IF YOU DO NOT ENROLL. ____

IF AVAILABLE, I ALSO WISH TO ENROLL IN:

Additional Purchase Life Insurance

If age-bracketed life plan, please choose the amount below:

- \$25,000 \$75,000
- \$50,000 \$100,00

(Please select one.)

- Dependent Life Insurance - Option 1**
(\$7,500 spouse & \$3,750 children)
- Double Dependent Life Insurance - Option 2**
(\$15,000 spouse & \$7,500 children)

Enter Employee Social Security Number _____

DEPENDENT INFORMATION

Complete this section if you are applying for family health, drug, or dental coverage or for dependent life or long term care coverage. List your spouse and any dependent children in descending age order. State the full name, relationship to you, date of birth, social security number, and gender for each person listed.

Is your spouse or any of your dependent children disabled? NO YES
If YES, please state the dependent's name(s) and the nature of the disability. _____
Please list the Medicare number if applicable. _____

First Name	MI	Relationship	Gender	mo	day	year
<input type="text"/>	<input type="text"/>	<input type="radio"/> Spouse	<input type="radio"/> Male	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name		<input type="radio"/> Child	<input type="radio"/> Female	Social Security Number		
<input type="text"/>		<input type="radio"/> Other _____		<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	MI	Relationship	Gender	mo	day	year
<input type="text"/>	<input type="text"/>	<input type="radio"/> Spouse	<input type="radio"/> Male	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name		<input type="radio"/> Child	<input type="radio"/> Female	Social Security Number		
<input type="text"/>		<input type="radio"/> Other _____		<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	MI	Relationship	Gender	mo	day	year
<input type="text"/>	<input type="text"/>	<input type="radio"/> Spouse	<input type="radio"/> Male	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name		<input type="radio"/> Child	<input type="radio"/> Female	Social Security Number		
<input type="text"/>		<input type="radio"/> Other _____		<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	MI	Relationship	Gender	mo	day	year
<input type="text"/>	<input type="text"/>	<input type="radio"/> Spouse	<input type="radio"/> Male	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name		<input type="radio"/> Child	<input type="radio"/> Female	Social Security Number		
<input type="text"/>		<input type="radio"/> Other _____		<input type="text"/>	<input type="text"/>	<input type="text"/>

First Name	MI	Relationship	Gender	mo	day	year
<input type="text"/>	<input type="text"/>	<input type="radio"/> Spouse	<input type="radio"/> Male	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name		<input type="radio"/> Child	<input type="radio"/> Female	Social Security Number		
<input type="text"/>		<input type="radio"/> Other _____		<input type="text"/>	<input type="text"/>	<input type="text"/>

SIGNATURE AND AUTHORIZATION

I understand that if I do not apply for health coverage when initially eligible and instead apply later, I and my dependents may have to exhaust a 12-month waiting period before coverage is effective. I understand that if I do not apply for other types of coverage when initially eligible and instead apply later, I and my dependents will be required to meet very strict standards of insurability and there is no guarantee I/we will be accepted for coverage. If any of the plans require a salary deduction, I hereby authorize my employer to make all necessary deductions.

SIGNATURE _____ DATE --

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