Northern School District Trust

Medical Enrollment Form

NSDT
c/o CESA #12
618 Beaser Ave
Ashland, WI 54806
Fax:715-682-7244

Employer

Employer District: Chequamegon Group #: 10004965

1st Date of Employment/Effective Date : _____

Employee

Last Name First M.I. Date of Birth S.S. #

_____ _____ _____

Address _____ Home Phone: _____

Gender: ___ M ___F

CSZ _____ Marital Status: ___ Single ___ Married

Medical Plan Selected: ___Traditional (PPO) ___ HDHP/HSA ___ Single ___ Family

* If enrolling in a Family Plan, please list your Spouse/Dependents

Spouse/Dependents

First Name M.I. Last Name	Date of Birth	S.S. #	Relationship

*** If Dependents listed above do not reside at the Employee address, list the dependent(s) name and address on the reverse side of this enrollment form.**

*** If you, your spouse, or any of your dependents have any other Medical coverage you must complete a Coordination of Benefits Form and send it with this application.**

Waive

I have decided not to apply for the coverage offered for: ___ Self ___ Dependents and I understand that this may affect applying for coverage at a later date.

_____ _____

Signature **Date**

Accept

I enroll for the eligible benefits I indicated above and authorize deductions from my earnings if required.

_____ _____

Signature **Date**