



# BENEFITS APPLICATION / CHANGE FORM

Employee I.D.: \_\_\_\_\_

NAME (Please Print) Last, First, Middle Initial	Health	Dental	Date of Birth	Sex	Social Security Number	Disabled
Employee (Subscriber)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### REASON FOR APPLICATION

NEW APPLICATION-(select one)	OR STATUS CHANGE-(select one)
<input type="checkbox"/> New Employee <input type="checkbox"/> Return from Leave	DATE OF EVENT: ____/____/____ <input type="checkbox"/> Marriage <input type="checkbox"/> Newly Eligible-Current Employee <input type="checkbox"/> Divorce <input type="checkbox"/> Termination of Other Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Return to Eligible Status <input type="checkbox"/> Death                                    Explanation: _____

### COVERAGE ELECTIONS

HEALTH/VISION		DENTAL	
Health Plan Options (select one)	Coverage Option (select one)	Dental Plan Options (select one)	Coverage Option (select one)
<input type="checkbox"/> PPO UnitedHealthcare <input type="checkbox"/> EPO UnitedHealthcare <input type="checkbox"/> HDHP UnitedHealthcare <input type="checkbox"/> Opt-Out Plan Option (See 2 (g) on reverse side) <input type="checkbox"/> I Waive Health Plan	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Delta Dental EPO <input type="checkbox"/> I Waive Dental Plan	<input type="checkbox"/> Single <input type="checkbox"/> Family

### SPOUSE &/OR DEPENDENTS TO BE ENROLLED

List **all** currently covered and newly eligible dependents/child(ren) and relationship to employee  
 USE THE FOLLOWING CODES: 01=Spouse 02=Child 03=Step Child 04=Legal Ward 05=Grandchild

NAME (Please Print) Last, First, Middle Initial	Health	Dental	Date of Birth	Relationship Code	Sex	Social Security Number	Disabled
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible
Dependent(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> Medicare Eligible

I certify that the above information is complete, true, and correct subject to State, Federal, and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependents. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members. I have read and understand the Terms and Conditions on the reverse side of this Benefits Application Change Form, and I have completed the required forms and/or provided documentation. As information requested on these forms changes, I understand I must promptly inform MPS Department of Benefits, Pension & Compensation in writing of the changes within 31 calendar days of a qualifying family status change or 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents. MPS reserves the right to determine eligibility and obtain all necessary information to accomplish same. (See Terms and Conditions on reverse side).

Signature: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Date: \_\_\_\_\_

## INSTRUCTIONS TO COMPLETE THE BENEFITS APPLICATION/CHANGE FORM HEALTH / VISION / DENTAL INSURANCE:

Please complete the Milwaukee Public Schools Benefits Application/Change Form if: you are enrolling for the first time or making a change to your current coverage as the result of a family status change.

- 1) Complete the Milwaukee Public Schools Benefits Application/Change Form by first indicating your Employee ID number and fully complete the first section starting with your Name, etc. Next select the Reason for Application - New Application or Status Change. If this is a Status Change, you must indicate the Date of the Event.
- 2) Select the Option for Health/Vision and/or Dental and select the Coverage Option (Single or Family). Please note that there are several Options to choose from for each plan. Note: The only vision provider is National Vision Administrators (NVA); and if you are electing health coverage, you are automatically enrolled in vision coverage. You cannot elect vision only coverage.
  - a) If you are an employee who is also covered as an eligible dependent under another MPS health plan, MPS Department of Benefits will terminate the dependent coverage and continue only your current employee coverage.
  - b) If you enroll in Single coverage for Health/Vision and/or Dental, please complete all requested information for yourself (Subscriber).
  - c) If you enroll in Family coverage for either Health/Vision and/or Dental, you must complete the Employee Spouse and/or Employee Dependent(s) section of this form for all eligible dependents in addition to yourself, if applicable. Please be sure to check the box, health/vision and/or dental coverage you wish for each dependent. Only **eligible** dependents will be accepted. Please refer to the Summary of Benefits on the MPS website for detailed information on eligible dependents. LIST ALL DEPENDENTS THAT YOU WISH TO COVER. COVERAGE WILL NOT BE EFFECTIVE FOR ANY DEPENDENTS YOU DO NOT INCLUDE ON THIS FORM.
  - d) If you are enrolling dependents other than your spouse, the following are valid options for Dependent(s): Natural or Adopted Child, Grandchild (must meet Dependent Eligibility requirements), Legal Ward/Guardian (documentation of such status is required), and Stepchild. Use the appropriate codes as listed for relation to employee.
  - e) If you have a disabled dependent, please indicate this in the appropriate column, and if that dependent is eligible for Medicare, please check the box "Medicare Eligible". MPS may request additional information to verify the disabled status of the dependent.
  - f) If you are enrolling any dependent(s) you must submit verification of dependent eligibility. For example, if you are enrolling a spouse and/or dependent child(ren), you must submit a marriage certificate and/or birth certificate(s). Failure to submit acceptable documentation to MPS Department of Benefits, Pension & Compensation can delay or possibly prevent the enrollment of your eligible dependents.
  - g) If you are enrolling in the Opt-Out Option, you will need to submit verification now as well as annual verification of current health coverage under another employer group health plan and the Payment in Lieu of Health Coverage form. For further information, please contact MPS Department of Benefits, Pension & Compensation or search *mConnect* for \$500 Opt-Out Option.

3) **Please retain a copy of the Benefits Application/Change Form for your records. Return completed forms and supporting documentation (if applicable) via fax (414) 475-8562 or: Milwaukee Public Schools  
Department of Benefits, Pension & Compensation  
5225 W. Vliet Street, Room 124  
Milwaukee, WI 53208**

### TERMS AND CONDITIONS

- 1) I hereby apply for enrollment/plan membership for the person(s) listed and agree that my dependent(s) and I shall abide by the provisions of coverage in the service agreement under which we are enrolled.
- 2) I understand enrollment is subject to all of the terms and conditions on the Master Group Policyholder Agreement with the provider I have chosen.
- 3) I hereby authorize deductions from my earnings of the required contributions, if any, toward the cost of the monthly premium required by Board Policy.
- 4) I consent and authorize any physician, dentist, consultant, hospital, or other person by whom any diagnosis, medical, surgical or dental treatment, or advice has been rendered to release pertinent medical, surgical, dental reports and records as requested to the insurance plan I selected, subject to all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
- 5) I understand that coverage is effective only upon timely submission of a complete application to MPS and, if applicable, the provider I have chosen.
- 6) I certify that the above information is complete, true, and correct subject to State, Federal and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependent(s). MPS reserves the right to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. As information requested on this form changes, I understand I must promptly inform MPS Department of Benefits, Pension & Compensation in writing of the changes – within 31 calendar days of a Qualifying Family Status Change or within 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Refer to the Summary of Benefits on the MPS website for additional details. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents.
- 7) MPS reserves the right to determine eligibility and obtain all necessary information to accomplish this. MPS also retains the right to conduct periodic audits, including random audits for eligibility verification. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members.