Employee Benefits Enrollment Form

TRISTAR Benefit Administrators
PO Box 65887
West Des Moines, IA 50265

Shaded Area Completed by Employer			
Group Number	Location	Employee Classification	Effective Date
33200			

1. Employee Information

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)	Sex: Male ☐ Female ☐
Home Mailing Address			Social Security Number	Home Telephone No.
City	State	Zip	Marital Status	Date Employed (mm/dd/yyyy)
Employer Name: **OKOBOJI CSD**			Email Address for Plan Correspondence:	

2. Complete this section to indicate the persons to be covered and the desired coverage

500 Plan	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Decline*
750 Plan	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Decline*

If you are declining enrollment for yourself or your dependents because of other health coverage, you may in the future, be able to enroll yourself or your dependents, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement fro adoptions.

Dependent	Name	Birth Date	Age	Sex	Post High School Student?
Spouse				Male ☐ Female ☐	☐Yes ☐ No ☐
Child				Male ☐ Female ☐	☐Yes ☐ No ☐
Child				Male ☐ Female ☐	☐Yes ☐ No ☐
Child				Male ☐ Female ☐	☐Yes ☐ No ☐
Child				Male ☐ Female ☐	☐Yes ☐ No ☐

3. Other Insurance Information

Is your spouse employed? Yes ☐ No ☐ If Yes, name of employer:

Does your spouse have a group health plan outside of this plan? Yes ☐ No ☐ If Yes, please indicate the coverage below:

Effective Date: Single Coverage ☐ Family Coverage ☐

4. Complete this information only if making a change.

☐ Name Change (Complete sections 1 and 5)
Former Name: New Name:

☐ Change from Single to Family Coverage (Complete all sections)
Reason for change: Date of Change: / /

☐ Change from Family to Single Coverage (Complete sections 1,2 and 5)
Reason for change: Date of Change: / /

☐ Adding Dependents with no change in Coverage (Complete all sections)
Reason for change: Date of Change: / /

☐ Terminate a dependent (Complete section 1)
Dependent(s) name: Last Date of Coverage: / /

5. Read and Sign

I understand that if I have made any false statements or misrepresentation or have failed to disclose or concealed any material fact TBA will be entitled to deny benefits. I agree that any surgeon, physician, dentist, pharmacist, nurse, hospital, or health care facility may furnish TBA with the diagnosis or medical records for any history of any past, present, or future treatments or conditions of all persons named herein.
I agree, upon request, to furnish TBA with all information required to administer the plan. If the plan requires contributions by me, I authorize my employer to deduct them from my pay.

Employee Signature ____ **Date** ____