# Enrollment Form

THE POOL
Western Michigan Health Insurance

| **Name of employer/plan sponsor:** | **Group #:** | **Plan choice:** |
|---|---|---|
| WMHIP – Ionia ISD | 71565 | ____ Enhanced 250 001 ____ Enhanced HSA Level 036/37<br>____ Enhanced 500 008 |

| **Check one:** | ☐ Initial | ☐ Change | ☐ Termination | ☐ Reinstatement |
|---|---|---|---|---|

| **Reason for change (check all that apply):** | **Date of hire:** |
|---|---|
| ☐ Initial Eligibility Following Hire<br>☐ Open Enrollment<br>☐ Status Change: _____<br>☐ Other: _____ | **Occupation:**<br>**Hours worked weekly:**<br>**Effective date of coverage or change:** |

| **Employee Name (last, first, middle initial):** | **Gender:**<br>☐ Female<br>☐ Male | **Date of Birth:** | **Social Security Number:** |
|---|---|---|---|
| **Street Address:** | **Telephone (including area code):** | | |
| **Email Address:** | Work: | Home: | |
| **City:** | **State:** | **ZIP Code:** | |

| **Dependent's Name** | **Relationship to Child** | **Birth Date** | **Social Security Number** | **Gender** | **Termination Date** |
|---|---|---|---|---|---|
| **Spouse:** | | | | ☐ Female<br>☐ Male | |
| **Child:** | ☐ Natural<br>☐ Step | | | ☐ Female<br>☐ Male | |
| **Child:** | ☐ Natural<br>☐ Step | | | ☐ Female<br>☐ Male | |
| **Child:** | ☐ Natural<br>☐ Step | | | ☐ Female<br>☐ Male | |
| **Child:** | ☐ Natural<br>☐ Step | | | ☐ Female<br>☐ Male | |

**Employee certification and signature:**

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a "change in status" or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.

| **Employee signature:** | **Date:** |
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