INDIANA UNIVERSITY

Open Enrollment 2009

IU PPO $900 Deductible Plan Health Care Enrollment Form

Retirees Under Age 65

Return to: University Human Resource Services, Attention: Karen Hill, 400 East 7th Street, Poplars E165, Bloomington, IN 47405

Participant Information

Name: _____ Social Security Number: _____-_____-_____
Last First MI

Date of Birth (mm/dd/yyyy): _____/_____/_____ Gender (circle one): M F

Address: _____
Street City State Zip

Phone: (_____) _____ - _____ E-mail: _____

Coverage Level

❑ CANCEL coverage for 2009; or

Please indicate the coverage level:

❑ Retiree Only
❑ Retiree & Participant (Spouse)
❑ Retiree & Child(ren)
❑ Family
❑ Spouse Only
❑ Spouse & Child(ren)

Dependent Information for Medical Plan Coverage

List *ALL* covered dependents (spouse and/or children) for which you wish to continue coverage.

Name	RC	DOB (mm/dd/yyyy)	M/F	Social Security Number

Relationship Codes (RC):
S – Legal Spouse/Domestic Partner
N – Biological/Adopted Child
G – Legal Ward
P – Stepchild
H – Disabled Child (over age 24)

Participant Authorizations and Certification

1. I request membership in the plan I have elected on this form, for which I am an eligible IU retiree/dependent.
2. I have read and understand the university's plan eligibility requirements; the dependents listed on this form meet all eligibility requirements.
3. I understand my duty to notify the university within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage or divorce.
4. I understand that enrolling a dependent who is not eligible, or failing to provide notice of ineligibility, can result in retroactive termination of health plan coverage for me and my dependents. I also understand that coverage of an ineligible dependent will result in liability on my part for costs paid by the plan while my dependent was ineligible.
5. I understand that the plan may use my personal health information for the purposes of treatment, payment, and health care operations and other uses as outlined in the plan's privacy notice, and consistent with federal HIPAA regulations.
6. The information supplied on this form is true and complete. I understand that any intentional false information or statements will be grounds for IU to void my coverage.

Participant Signature_____ Date_____

Make a copy for your records.