

**This box is for PEB use only**

Effective Date: \_\_\_\_\_

New enrollee  Open Enrollment  Other Change: \_\_\_\_\_  
(Specify type of change)

From: \_\_\_\_\_  single  domestic partner  family  surviving spouse  
To: \_\_\_\_\_  single  domestic partner  family  surviving spouse

*Ball State University*  
**Group Health Care Enrollment Form**  
*Group # 9009*

**A. Choose your health plan option by checking one of these boxes:**

**Low Deductible PPO 0075**

**HD/HSA PPO 0079**

**Wellness PPO 0077**

**B. Employee Information (Please print clearly)**

\_\_\_\_\_  
Last name First name M.I. Social Security Number

Address: \_\_\_\_\_  
Street City/State Zip

Sex: Male  Female  Birth date: \_\_\_\_\_ Daytime telephone: \_\_\_\_\_

Marital status: Single  Married  Surviving Spouse

Email address: \_\_\_\_\_

**C. Employment Information (Please print clearly)**

Hire date: \_\_\_\_\_ Dept./Work location: \_\_\_\_\_ Dept/Work telephone: \_\_\_\_\_

**D. Medical/Dental coverage level elections (Complete D.1 below if family or domestic partner is selected)**

Single  Family  Domestic Partner\*  Effective date: \_\_\_\_\_

**D.1 Dependent information (Please print clearly)**

Relationship	Last Name	First Name	M.I.	Date of Birth	Male	Female

\*Domestic Partner coverage is only available for same sex domestic partners. The employee and partner must read and sign the Affidavit of Domestic Partner Relationship which may be obtained in the Payroll & Employee Benefits Office, Room G29, Administration Bldg.

**E. Other insurance information (Please print clearly)**

Are you or any of your dependents covered under another **medical** plan? yes  no  *If yes, complete E.1 below*  
Are you or any of your dependents covered under another **dental** plan? yes  no  *If yes, complete E.2 below*

**E.1**  
Name/Address of *other Insurance Company*: \_\_\_\_\_  
Phone number of other Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policyholder name: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_  
Individuals who are covered by this other policy: \_\_\_\_\_

**E.2**  
Name/Address of *other Insurance Company*: \_\_\_\_\_  
Phone number of other Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policyholder name: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_  
Individuals who are covered by this other policy: \_\_\_\_\_

I hereby request coverage under the Group Policy(s) offered by Ball State University (BSU) and I authorize deductions from my earnings for any required or owed premium contributions. I hereby authorize hospitals, physicians, dentists or other providers of service, including a BSU sponsored wellness program, to furnish to Key Benefit Administrators, Inc. or its agents, upon request, any and all reports, records or copies thereof concerning any illness, injury or condition for which service was provided to my or my dependants together with like reports, records or copies thereof for all earlier services. I further understand that changes to enrollment are generally not permitted during the year, except during a Qualified Open Enrollment Period. However, if I have a change in family status I may make changes such as adding a new spouse or new baby, within 30 days of the event. (Additional events may also qualify; see the BSU website @ [www.bsu.edu/payroll](http://www.bsu.edu/payroll) for details.) You may keep the yellow copy of this form for your records.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_