REEP CompleteCare Enrollment Form

EMPLOYER INFORMATION

Employer Name (Enter your School District):

Please complete & sign this form and send information to your District's Benefits Office

I am enrolling in CompleteCare for (Please circle one): **Self Only** **Self & Family** **Self & Child(ren)** **Spouse Only** **Child(ren) Only** **Spouse & Child(ren)**

CLASSIFICATION (Please circle one): **Management** **Confidential** **Supervisory** **Classified** **Certificated**

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: ☐ M ☐ F	CompleteCare Effective Date:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ☐ M ☐ F
Social Security No:	Spouse's Employer:	
Spouse's Pay Period for Health Premium Contribution: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly		
Spouse's Health Premium Contribution per Pay Period: $ _____ ** **INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT**		
Are Spouse's Health Premium Contribution / Deductions: ☐ Before Taxes **(OR)** ☐ After Taxes		

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spouse's paystub, please circle the contribution/deduction amount on the paystub.
* DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse's paystub that shows the NEW contribution/deduction as of the CompleteCare effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan. *Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may be only once a month or the first two pays of each month.*

*** If your spouse's plan has a High Deductible with a Health Savings Account (HSA), you are not eligible to participate in CompleteCare, unless the Employer allows your spouse to drop the HSA portion of the plan. Written documentation required. Also, if your primary health coverage is through Medicare, Tricare (Retiree only) or Medicaid, you are not eligible for CompleteCare.**

***You are not eligible to enroll in the CompleteCare plan if you or your spouse work for another REEP school district.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored CompleteCare. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am *not eligible* to participate in CompleteCare offered through my employer.**

Employee Signature: **Date:**