MEDICAL & DENTAL GROUP COVERAGE ENROLLMENT FORM

Medical Plan: 051370 ☐ Government/RTC PPO Plan (SA 051386) ☐ Government/RTC HSA Plan (SA 051387)

Dental Plan: 50825 ☐ Public Safety/Resource Mgmt. PPO (SA 051384) CL04/CL14/CL08/CL18

Company Name: Leech Lake Band of Ojibwe/RTC Government

Date of Hire: / /		**Enrolled member of Federally recognized Tribe:** ☐YES ☐NO	
1. Legal Name: **Last:**	**First:**	**M.I.:**	**2. Social Security Number** - -
3. Sex: ☐ Male ☐ Female	**4. Marital Status:** Married ☐ Single☐		**5. Birth Date:** / /
6. Mailing Address: Street/PO Box:	City:	State:	Zip:
Coverage Applying For? ☐ Medical ☐ Dental			
7. Medical Coverage: ☐ Single ☐ Family *(IF WAIVING COVERAGE, COMPLETE #9)*		**Dental Coverage:** ☐ Single ☐ Family *(IF WAIVING COVERAGE, COMPLETE #9)*	

IHS Eligible	Primarily Use IHS
YES ☐ NO ☐	YES ☐ NO ☐

8. Employee/Dependent Coverage

Include Dependent Status* (list all that apply). If you need more space, please use reverse side

* A = Adopted F = Foster Child C = Step Child G = Grandchild N = Natural Child H = Handicapped

Legal Name (Last, First Middle)		Dep. Status	Social Security #	Gender	Date of Birth	Enrolled member of Federally recognized Tribe
Employee			- -	☐ M ☐ F	/ /	☐YES ☐NO
Spouse			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO
			- -	☐ M ☐ F	/ /	☐YES ☐NO

Is any dependent being covered by court order? If yes, who? Please provide copy of the court order. Name:

9. I DECLINE COVERAGE FOR: (Please sign HIPPA waiver form)

Medical: ☐ Myself ☐ My Dependents **Dental:** ☐ Myself ☐ My Dependents

I understand that in order to enroll in the group benefits through Leech Lake Band of Ojibwe at a future date, I may enroll during Open Enrollment or have a qualifying life event.

To the best of my knowledge the above information is true and correct and I hereby request the coverage indicated above and authorize my company to deduct the required contributions, if any, from my earnings.

Signature: **Date Completed**: / /