SCHOOLS HEALTH INSURANCE FUND

Affirmative Election Form

FAILURE TO COMPLETE & RETURN THIS FORM WILL RESULT IN A CHANGE TO YOUR BENEFITS

Employer Name: _____

EMPLOYEE/PARTICIPANT INFORMATION

Please **PRINT** and fill this section out **COMPLETELE**

Social Security #:	Last Name:		First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:		Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	**Effective Date: 1/1/2021**			

I understand by signing this form, I choose to stay in my current plan for 1/1/2021. I also understand that I am not able to make any changes to my plan or plan section until the next open enrollment period, unless I have a qualifying life event.

If you experience a qualifying life event and need to make a change, please contact your personnel department, within 30 days of the event. Examples of a qualifying life event are the following:

- Marriage
- Birth or adoption of a child
- Loss or reduction of coverage for you or your spouse
- Death of a covered dependent
- Divorce

Employee Signature

Print Name: _____

Employee Signature: _____

Date:_____