Affirmative Selection Form
Effective January 1, 2021

EMPLOYEE PARTICIPANT INFORMATION

PRINT and fill out this section COMPLETELY

Social Security #:	Date of Birth:	First Name:	Last Name:	M.I.:

Select one option only:

_____ I am an employee with an employment/start date prior to July 1, 2020 and I want to remain in my **CURRENT HEALTH PLAN which includes PRESCRIPTION DRUG** effective January 1, 2021. I also understand that I am not able to make any changes to my plan or plan selection until the next open enrollment period unless I have a qualifying event.

_____ I am an employee with an employment/start date prior to July 1, 2020 and I want to enroll in the **Direct Access, POS, EPO, HDHP** or **HORIZON EDUCATORS HEALTH and EDUCATORS PRESCRIPTION DRUG PLAN** effective January 1, 2021. I also understand that I am not able to make any changes to my plan or plan selection until the next open enrollment period unless I have a qualifying event. I will complete a new medical and prescription drug enrollment form and return to the Business Office.

_____ I am an employee with an employment/start date prior to July 1, 2020 and I elect to continue to **WAIVE** coverage. I understand I must provide proof of other coverage.

_____ I am an employee with an employment/start date prior to July 1, 2020 and currently **WAIVE** and now elect to enroll in the **Direct Access, POS, EPO, HDHP**, or **HORIZON EDUCATORS HEALTH PLAN and EDUCATORS PRESCRIPTION DRUG PLAN** effective January 1, 2021. I understand I will need to complete a medical and prescription enrollment form and return to

_____ I am an employee with an employment/start date on or after July 1, 2020 and understand my only plan option is the **HORIZON EDUCATORS HEALTH PLAN and EDUCATORS PRESCRIPTION DRUG PLAN** effective January 1, 2021. I understand this will mean a change to my Medical and Prescription benefits. I will complete a new medical and prescription enrollment form and return to the Business Office.

_____ I am an employee with an employment/start date on or after July 1, 2020 and I am electing to **WAIVE** my coverage effective January 1, 2021. I understand I must provide proof of other coverage.

If you experience a qualifying life event and need to make a change, please contact your Human Resources or Benefits Department, within 30 days of the event. Examples of a qualifying event are the following:

* *Marriage*
* *Loss or reduction of coverage for your or your spouse*
* *Birth or Adoption of a child*
* *Divorce*
* *Death of a covered dependent*

Employee Signature
Employee Signature:
Date:

This Section for Employer Use Only	
Approved by:	Date: