Return form to Heather Orosz, Benefits Office by May 31,2023) Employer Name: Simsbury Public Schools Employer Address: 933 Hopmeadow St, Simsbury, CT 06070 Employee Branch/Division/Class: UNAFF - Unaffiliated / Nutrition Srvs / SEED / DCE		CIGN		ENT / CHANGE FC	RM				
Employee Branch/Division/Class: UNAFF – Unaffiliated / Nutrition Srvs / SEED / DCE Choose Plan Type: (Choose only one) Open Access Plus - OAP In-Network Only Open Access High Deductible Health Plan with Health Savings Account – HDIP/HSA High Deductible Health Plan with Health Reimbursement Account – HDIP/HSA (PPO) In-Network Only Open Access Plus – OAP-IN (HMO) High Deductible Health Plan with Health Reimbursement Account – HDIP/HSA (PPO) In-Network Only Open Access Plus – OAP-IN (HMO) High Deductible Health Plan with Health Reimbursement Account – HDIP/HSA (PPO) In-Network Only Open Access Plus – OAP-IN (HMO) High Deductible Health Plan with Health Reimbursement Account – HDIP/HSA (PRoase Print) EMPLOYEE FIRST NAME: MI Social Security Number (PRoase Plant (MACD-YYY) () () Social Security Number (MACD-YYY) () () State Zip Code INVOLID LIKE COVERAGE FOR ME AND MY DEPENDENTS SOCIAL SECURITY NUMBER Date of BIRTH GENDER (Specify last name if different from yours) Employee Date of BIRTH GENDER Spouse Dapendent* Date of BIRTH Date of BIRTH Date of BIRTH Dependent* Date of BIRTH	Group Number: 3211196								
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Dependent*	(Specify last name if different from yours)							GENDER	
	Dependent*								
EMPLOYEE'S SIGNATURE / DATE EMPLOYER'S SIGNATURE / DATE	Dependent*								
	EMPLOYEE'S SIGNATURE / DATE			EMPLOYER'S SIG	EMPLOYER'S SIGNATURE / DATE				

*Dependents – Dependents are covered under the medical plan up to age 26. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.