LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT.

Office of Human Resources
1419 Salt Springs Road
Phone: 315.445.4155
Fax: 315.445.6023

Open Enrollment Form

Name: _____ SSN: _____

Address: _____

City, State Zip: _____

Date of Birth: _____ Gender: _____ Phone #: _____

Email Address: _____

Medicare # (if applicable): _____ Part A Effective: _____ Part B Effective: _____

Only complete this section if you are enrolling in a **FSA and/or changing your dependents covered on your **medical plan.***

☐ I do not have a spouse or any dependents, and therefore, I do not have to complete this section.

Name	SSN	Date of Birth	Gender	Relationship

Other coverage information - **Only complete this section if you are enrolling in the **medical insurance** as a new enrollee.*

1. Have you, your spouse, or any enrolled dependent had other medical coverage within the last 63 days? ☐Yes ☐No
2. If yes, are you keeping the additional medical coverage? ☐Yes ☐No
3. Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children
4. Other insurance carrier name? _____
5. Name of policyholder: _____
6. Policy ID #: _____ Effective date: _____ Term date: _____

Please check coverage type and person(s) to be covered:

☐ Medical: ☐ New enrollee ☐ Change in plan or persons covered
☐ PPO-J ☐ HealthyBlue
☐ single ☐ ee & spouse ☐ ee & dependents ☐ family
Please specify dependents to be ☐ removed or ☐ added (if applicable): _____

☐ Flexible Spending Acct: ☐ Health Care: Pay period amt: _____ x #of pay periods: ___ = Total amt: _____
☐ Automatic Claims Transfer
☐ Dependent Care: Pay period amt: _____ x #of pay periods: ___ = Total amt: _____
☐ Direct deposit election (complete this section if you want Direct Deposit)
Type of acct: ☐ Checking ☐ Savings
Name of Bank: _____
Routing #: _____ Acct #: _____

☐ Vol. Life & AD&D: Please complete The Hartford's Life & AD&D Enrollment Form & the Personal Health App

☐ AFLAC – I would like more information in regards to the ☐ Cancer coverage and/or the ☐ Accident coverage

Participant Signature: _____ Date: _____

To be completed by the employer:
Effective date: _____
Benefit Log: _____
BCBS: _____ EBS-RMSCO: _____