

# FACULTY INSURANCE - ENROLLMENT AND PLAN SELECTION FORM

*Please review Faculty Rate Sheet for monthly premiums and fringe information*

MEDICAL INSURANCE	Single	2-Party	Family	Decline**
<small>Employees newly enrolling in SISC medical must complete a SISC Enrollment Form. After initial enrollment, adding or removing a dependent requires a SISC Change Form.</small>				
SISC Anthem PPO A - Group # 40303A (80-E)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISC Anthem PPO B - Group # 40303B (80-G)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISC Anthem PPO C - Group # 40303C (80-L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISC Anthem PPO D - Group # 40303D (80-M)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISC Anthem PPO E - Group # 40303E (HSA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISC Anthem PPO F - Group #70303B (Anchor Bronze)*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Employee & child/children ONLY; Spouse/Domestic Partner are not eligible for this plan				
**Full-time Faculty must enroll in medical insurance				
SISC Dependent Information				
NAME	Social Security #	Date of Birth	Gender	Relationship
DENTAL INSURANCE	Single	2-Party	Family	Decline
<small>Per plan policy, this dental insurance coverage requires a minimum 2-year commitment</small>				
Delta Dental Plan A - Group #6736-0001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Dental Plan B - Group #6736-0003	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Dental Plan C - Group #6736-01001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Dental Plan D - Group #6736-01003	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Dependent Information				
NAME	Social Security #	Date of Birth	Gender	Relationship
VISION INSURANCE	Single	2-Party	Family	Decline
VSP Vision Insurance - Group #30071230	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Dependent Information				
NAME	Social Security #	Date of Birth	Gender	Relationship
<small>Print Employee Name</small>	<small>Signature</small>	<small>Banner ID</small>	<small>Date</small>	