GRA Healthcare Option Enrollment/Cancellation Form

GRA Information

Student Name: _____ Date: _____
Last *First* *M.I.*

Department: _____

Employee ID _____

Address Information

Street Address: _____

City _____ State/Zip: _____

E-mail Address: _____ Cell Ph.: _____

Enrollment Information

☐ I am currently enrolled in the GRA Healthcare plan and wish to cancel my coverage effective January 1, 2017.
If you are currently enrolled in the GRA Healthcare plan and wish to continue your coverage, no action is required on your part.

☐ I elect to enroll in the GRA Healthcare option through the University System of Georgia. I have read the Summary of Benefits and understand the benefits under the plan. I understand that I am unable to make changes to this coverage during the year unless I experience a qualifying life event (such as birth or adoption of a child). If I no longer serve in a position that is eligible for coverage, the coverage will be terminated and I will be offered the option to enroll in COBRA based coverage.

By enrolling in this plan, I authorize KSU to take payroll deductions out of my paycheck for the amount listed below. For any month(s) in which my paycheck does not cover the cost of the insurance, I understand that I will need to provide payment directly to KSU for the cost of this coverage or my coverage will be cancelled.

Monthly Premium	GRA Pays	USG Pays	Total Premium
Single Coverage - GRA Only	$94	$312	$406
Family Coverage - GRA & Eligible Child(ren)	$419	$312	$731

I understand that it is my responsibility to notify KSU HR (via benefits@kennesaw.edu or by fax at 470-578-9174) of any changes to the eligibility of my dependent(s).

Dependent Child(ren) Enrollment Information

Dependent Child(ren) Name	Date of Birth	Social Security Number	Gender

Dependent Child Eligibility Definition: You natural, adopted, or step child(ren) up to age 26; your disabled child(ren) with proof of disability. Documented proof of dependent child(ren) eligibility is required.

Tobacco Use Status: ☐ Yes, I am a Tobacco User ☐ No, I do not utilize Tobacco

I hereby attest that the above information is true and correct. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Board of Regents of the University System of Georgia regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

_____ _____
Signature Date