PARKWAY SCHOOLS

OPEN ENROLLMENT

RETIREE/COBRA/LOA

Plan Year: 01/01/2025-12/31/2025

USE ONLY DURING OPEN ENROLLMENT FOR 2025 BENEFITS

Plan Subscriber's Information:

The Plan Subscriber (Primary holder of the insurance policy) must complete this form and sign to authorize the changes requested.

Legal Full Name:_____ Date of Birth:_____

Street Address:_____ City, State, ZIP:_____

E-Mail Address:_____ Phone Number:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

NO ACTION IS NECESSARY TO KEEP YOUR CURRENT BENEFITS

If you do not complete and return this form, your current benefits elections will rollover to the 2025 plan year.

TO CHANGE YOUR BENEFITS

Please complete the this form and indicate your elections for the 2025 plan year in ALL sections.

You cannot add new Medical, Dental, or Vision coverage if you are not currently enrolled in the respective plan.

MEDICAL: Check the box for your medical plan choice and coverage level. ☐ **DECLINE MEDICAL**

Plan Choice:

- ☐ United Healthcare Base
- ☐ United Healthcare Premium
- ☐ United Healthcare HDHSA
- ☐ Aetna Medicare Advantage (enrolled in Medicare Part B) – call Parkway for Aetna Enrollment Form
- ☐ Anthem Medicare Advantage (enrolled in Medicare Part B) – call Parkway for Anthem Enrollment Form

Coverage Level:

- ☐ Self Only
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

DENTAL: Check the box for your dental plan choice and coverage level. ☐ **DECLINE DENTAL**

Plan Choice:

- ☐ Delta Dental

Coverage Level:

- ☐ Self Only
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

VISION: Check the box for your vision plan choice and coverage level. ☐ **DECLINE VISION**

Plan Choice:

- ☐ EyeMed Vision

Coverage Level:

- ☐ Self Only
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

DEPENDENT INFORMATION

Complete this section if electing coverage for your spouse and/or child(ren). Please indicate which coverage(s) each individual is enrolling in by putting an X in under Medical, Dental and/or Vision.

Legal Full Name	Date of Birth	Medical	Dental	Vision
SPOUSE:				
CHILD:				
CHILD:				
CHILD:				

AUTHORIZATION FOR ENROLLMENT

I authorize Parkway School District to enroll the coverage(s) checked for the listed participants. I understand the following: any changes are non-reversable, coverage can be canceled at any time, coverage cannot be reinstated once dropped. *Exceptions may apply for retirees if a request for reinstatement is made within one (1) year of retirement.*

Plan Subscriber's Signature:_____ **Date:**_____

Return by Mail:
Parkway School District
Attn: Benefits
455 N. Woods Mill Rd
Chesterfield, MO 63017

Return by Email/Scan:
benefits@parkwayschools.net

Drop form off:
Administrative Building

OPEN ENROLLMENT ELECTIONS ARE EFFECTIVE JANUARY 1st, 2025