

STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

APPLICATION/POLICY CHANGE/TERMINATION

(Please use Blue or Black Ink Only)

ENROLLEE: Policy Change New Enrollee Termination **EFFECTIVE DATE:** _____

Employee's Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip Code _____ Phone _____

Hire Date (mo/day/yr) ____/____/____ Sex Male Female Employee's Social Security # _____

Employee Date of Birth (m/day/yr) ____/____/____ Marital Status Single Married Divorced Widowed

Date Married: (month/day/year) ____/____/____

INSURANCE DESIRED:

HEALTH

SUPERMED PLUS PPO —418470- _____ Single Family

AULTCARE PPO—21804M - _____ Single Family

BRONZE PLAN—418470- _____ Single Family

DENTAL —418470 _____

Single Family

VISION—418470 _____

Single Family

CHANGES: Name(s) of Member/Dependents to be Changed/Added/Termed _____

ADD DUE TO: Marriage Birth Adoption Date of _____

TERMINATE DUE TO: Divorce Left Employ Ineligible Request Cancel Death Death

Relationship							<u>Over Age Status</u>	
Child/ <u>Spouse</u>	<u>Birthdate</u> Mo/Day/Yr	<u>Sex</u> M/F	<u>Last Name</u> (Only if Different)	<u>First Name</u>	<u>Social</u> Security #	<u>Full-Time**</u>	<u>Student</u>	<u>Disabled</u>
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

**Completed Adult Dependent Certification Form required for dependent child between 19 and 26 for Dental and/or Vision coverage.

MEDICARE Are you covered by Medicare? Yes No If YES, Medicare # _____ Effective Date _____ Hemodialysis

INFORMATION Is your spouse covered by Medicare? Yes No If YES, Medicare # _____ Effective Date _____ Hemodialysis

OTHER Do you or any of your family members have other health/dental insurance? YES NO
INSURANCE If YES, employed by: _____ ACTIVE RETIRED

INFORMATION Names of Insured: _____

Name of Insurance Carrier _____

Address _____ Policy No. _____ Single Family

When did this insurance become effective? _____

TERMS AND CONDITIONS: Your signature on this form will indicate your understanding that your employer will enroll you for all group health plan coverages for which you are eligible and will constitute your authorization to your employer or any of its agents to release to all administrators, carrier, or health care coverage organizations, as applicable, the information contained on this form.

Each dependent listed on this form must be an eligible dependent in accordance with your group health care plan.

Your signature on this form constitutes your authorization to any health care coverage carrier, organization, employer Medicare-approved organization, or provider of services to release any information necessary to process a claim.

SIGNATURE _____ Date _____

Employer Representative _____ Date _____ Notes: _____