

STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

APPLICATION AND POLICY CHANGE

(Please Use Ball Point Pen)

EFFECTIVE DATE: _____

ENROLLEE: POLICY CHANGE NEW ENROLLEE

LAST NAME _____ FIRST NAME _____ MI _____

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

Employee Date of Birth: MO _____ DAY _____ YR _____ Sex: M F Employee Social Security Number _____ Marital Status: Single Married Divorced Widowed Date Married: MO _____ DAY _____ YR _____

Employer Company Name _____ Date of Hire- Full Time: MO _____ DAY _____ YR _____ Job Title _____

HEALTH INSURANCE DESIRED:	MEDICAL MUTUAL-Traditional (80/20)	SUPERMED PLUS -PPO (90/10)	AULTCARE-PPO (90/10)
	Group # _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family	Group # _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family	Group # _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family

RELATIONSHIP*	BIRTHDATE Mo Day Yr	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOCIAL SECURITY NO.	OVER AGE DEPENDENT STATUS	
						FULL-TIME STUDENT	HANDICAPPED
SPOUSE		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					

* LEGAL DOCUMENTATION (COURT DECREE, GUARDIANSHIP PAPERS, ETC.) MUST BE ATTACHED TO THIS APPLICATION IF RELATIONSHIP IS MARKED OTHER.

CHANGES: New Name Other _____
 New Address
ADD DEPENDENTS DUE TO: Marriage Birth Adoption Change to Medicare Elig Change Coverage
DROP DEPENDENTS DUE TO: Divorce Death Other _____

DATE OF EVENT
MO _____ DAY _____ YR _____

COV. OR CHANGE EFF. DATE
MO _____ DAY _____ YR _____

MEDICARE INFORMATION Are you covered by Medicare? YES NO If YES, Medicare # _____ Effective Date: _____ Hemodialysis
 Is your spouse covered by Medicare? YES NO If YES, Medicare # _____ Effective Date: _____ Hemodialysis

OTHER INSURANCE INFORMATION Do you or any of your family members have other health/dental insurance? YES NO
 If YES, employed by: _____ ACTIVE RETIRED
 Names of Insured: _____
 Names of Insurance Carrier _____
 Address _____ Policy No. _____ Single Family
 What date did your prior/current health insurance program become effective _____
 (check box if no prior/current coverage)? No Coverage
 What date did/will your prior/current health insurance program terminate _____
 (check box if no prior/current coverage)? No Coverage

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, carriers, 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 _____

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. (OHIO REVISED CODE SECTION 3999.21)

NOTES: _____
 EMPLOYER REPRESENTATIVE _____ DATE _____