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

_____

Employee Date of Birth Sex Employee Social Security # Marital Status Date Married

MO DAY YR M___ F___ _____ ___Single ___Married MO DAY YR

___/___/___ ___Divorced ___Widowed ___/___/___

INSURANCE DESIRED:

HEALTH

SUPERMED PLUS PPO —418470-682 **___Single ____Family**

DENTAL —418470-683

___Single ____Family

VISION—418470-684

___Single ____Family

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

ADD DUE TO: Marriage____ Birth____ Adoption____

TERMINATE DUE TO: Divorce____ Left Employ____ Ineligible____ Request Cancel____ Death____ Death of Death_____

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

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

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:_____

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:_____