## **CASEBP** DENTAL PLAN

## MEMBERSHIP APPLICATION

LAST NAME    FIRST    INITIAL    SOCIAL SECURITY NUMBER      STREET ADDRESS    C/O    COUNTY      CITY    STATE    ZIP CODE    PHONE #      SEX    DATE OF HIRTH    MARITAL STATUS    MARRIAGE DATE      MALE_FEMALE    DAT OF HIRTH    MARITAL STATUS    MARRIAGE DATE      MALE_FEMALE    MO DAY YR    _SINGLE_MARRIED    MARRIAGE DATE      MALE OF EMPLOYER    EMPLOYMENT DATE			ORMATION MUST BE PI ADDITION	PROVIDED. PLEASE TYPE OR PRI EXISTING SUBSCRIBER			
CITY      STATE      ZIP CODE      PHONE #        SEX      DATE OF BIRTH      MARITAL STATUS      MARRIAGE DATE        MALE_FEMALE      DATE OF BIRTH      MARRIAE STATUS      MARRIAGE DATE        MARE OF EMPLOYER      EMPLOYMENT DATE        Milford Central School      FEDERAL MEDICARE CLAIM NUMBER:        ADDRESS OF EMPLOYER      FEDERAL MEDICARE CLAIM NUMBER:        4 W Main Street     MEDICARE PART & EFFEC. DATE        4 W Main Street     MEDICARE PART & EFFEC. DATE        Milford, NY 13807     MEDICARE PART & EFFEC. DATE        Check desired coverage:     INDIVIDUAL      _2-PERSON       KHIGH-LEVEL PLAN     MID-LEVEL PLAN       KHIGH-LEVEL PLAN     MID-LEVEL PLAN       KHIGH-LEVEL NOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE        PLEASE NOTE: INCOMPLETE INFORMATION COULD RISULT IN CLAIM DINIALS       KAMB     MENT       MAMB     MENT       NAMB     MENT       NAMB     MENT       NAMB     MENT       MAMB     MENT       MAMB     MENT       MAMB     MENT       MAMB     MENT       MAMB     MENT	LAST NAME		FIRST	INITIAL		SOCIAL SECURITY NUMBER	
SEX      DATE OF BIRTH      MARITAL STATUS      MARRIAGE DATE	STREET ADDRESS		C/O			COUNTY	
	CITY S		STATE	ZIP CODE		PHONE #	
Milford Central School        ADDRESS OF EMPLOYER      FEDERAL MEDICARE CLAIM NUMBER: 							
ADDRESS OF EMPLOYER      FEDERAL MEDICARE CLAIM NUMBER:        4 W Main Street	NAME OF EMPLOYER					EMPLOYMENT DA	TE
4 W Main Street     MEDICARE PART A EFFEC. DATE							
4 W Main Street     MEDICARE PART B EFFEC. DATE	ADDRESS OF E	MPLOYER					
Milford, NY 13807	4 W Main Street						
X HIGH-LEVEL PLAN     MID-LEVEL PLAN        LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        LAST      PIRST      DATE OF HIRTH      RELEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        LAST      PIRST      DATE OF HIRTH      RELEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        LAST      PIRST      DATE OF HIRTH      RELEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        On the structure      PIRST      DATE OF HIRTH      RELEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        On the effective date of this contract, do you or your spouse have coverage through another MEDICAL HEALTH PLAN? Yes _No if yes, indicate Carrier Name of Policyholder Name of Policyholder 							
Image: Sector of the sector	Check desired coverage:		_INDIVIDUAL	2-PE	RSON	FAMILY	
PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS        LAST      FIRST      DATE OF BIRTH      RELATIONSHIP      SOCIAL      IS        MAME      Image: gray of the provided state of the contract, do you or your spouse have coverage through another MEDICAL HEALTH PLAN?      Image: gray of the provided state of the provid			$\underline{X}$ HIGH-LEVEL PLAN	MID	-LEVEL PLAN		
NAME      MO DAY YR      (HUBRAND, WIFE, SECURITY)      SECURITY      MEMBER DISABLED        Image: Son, OR DAUGHTER)      #      DISABLED      #      DISABLED        Image: Son, OR DAUGHTER)      #      DISABLED      #      DISABLED        Image: Son, OR DAUGHTER)      #      DISABLED      Image: Son, OR DAUGHTER)      #      DISABLED        Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      DISABLED        Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      DISABLED        Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      DISABLED        Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      Image: Son, OR DAUGHTER)      #      DISABLED        On the effective date of this contract, do you or your spouse have coverage through another MEDICAL PLAN?      #      #      #      DISABLED		PLEASE 1					
Yes _No      If yes, indicate Carrier			FIRST		(HUSBAND, WIFE,	SECURITY	MEMBER
Yes _No      If yes, indicate Carrier							
Yes _No      If yes, indicate Carrier							
Yes _No      If yes, indicate Carrier							
Yes _No      If yes, indicate Carrier							
employer immediately.        SIGNATURE	YesNo On the effective d YesNo	If yes, indicate C Name of Policyho Individual Contra ate of this contract If yes, indicate C Name of Policyho Individual Contra	arrier older Family Contract i, do you or your spouse have arrier older ict Family Contract	e coverage through	another DENTAL	PLAN?	ll notify my
EMPLOYER STATEMENT: Work Status:     Full-time      _On Leave     Retired (date)        Date of Employment:       Dental Effective Date:       Termination Date:	employer immedia	tely.					5 5
Date of Employment:     Dental Effective Date:	SIGNATURE				DATE		
	EMPLOYER STATEMENT: Work Status:		Status:Full-time	Part-time	On Leave	Retired (date)	
Employer Representative:     Date:	Date of Employme	nt:	Dental Effective D	Date:		Termination Date:	
	Employer Represen	ntative:		_ Date:			