

COUNTY STATE ZIP CODE PHONE # SEX DATE OF BIRTH MARITAL STATUS MARRIAGE DATE MALE _FEMALE MO DAY YR SINGLE _MARRIED MO DAY YR NAME OF EMPLOYER SOUTH KORTRIGHT CENTRAL SCHOOL ADDRESS OF EMPLOYER SEMPLOYER FEDERAL MEDICARE CLAIM NUMBER: MEDICARE PART A EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE SOUTH KORTRIGHT, NY 13842 Check desired coverage: INDIVIDUAL LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS LAST NAME PERST DATE MEDICARE PART B EFFEC. DATE MID-LEVEL PLAN LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT. IN CLAIM DENIALS LAST NAME PERST DATE MEDICARE MEDICAL MEDICAL MEDICAL MEDICAL MEDICAL	ALL INFORMATION MUST BE PR PLEASE INDICATE: NEW ADDITION		EXISTING SUBSCRIBER			
SEX DATE SIRTH MARITAL STATUS MARRIAGE DATE MALE FEMALE MO DAY YR SINGLE_MARRIED MO DAY YR SINGLE_MARRIED MO DAY YR SINGLE_MARRIED MO DAY YR NAME OF EMPLOYER SOUTH KORTRIGHT CENTRAL SCHOOL ADDRESS OF EMPLOYER FEDERAL MEDICARE CLAIM NUMBER: S8200 NY-10 MEDICARE PART A EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE MEDICARE PART B EFFEC. DATE LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS LAST NAME FIRST DATE OF MARITY SELECTION SCHOOL MARITY SELECTION DISCASSIBLE SCHOOL MARITY SCHOOL	LAST NAME	FIRST	INITIAL		SOCIAL SECURITY NUMBER	
DATE OF BIRTH MARITAL STATUS MARRIAGE DATE MALE _FEMALE MO DAY YRSINGLE _MARRIED MO	STREET ADDRESS	C/O			COUNTY	
MALE_FEMALE MO DAY YRSINGLE_MARRIED MO DAY YR NAME OF EMPLOYER SOUTH KORTRIGHT CENTRAL SCHOOL ADDRESS OF EMPLOYER FEDERAL MEDICARE CLAIM NUMBER:	CITY	STATE	ZIP CODE		PHONE #	
South Kortright Central School ADDRESS OF EMPLOYER	SEXMALEFEMALE					
ADDRESS OF EMPLOYER	NAME OF EMPLOYER				EMPLOYMENT DA	TE
Sazon NY-10 South Kortright, NY 13842 Check desired coverage:INDIVIDUAL		ool				
LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS PREST DATE OF BIRTH ORDER OF AGE	58200 NY-10		MEI	DICARE PART A	EFFEC. DATE	
LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS LAST PIEST DATE OF BIRTH RELATIONSHIP SOCIAL S	Check desired coverage:	_INDIVIDUAL	2-PERSON		FAMILY	
PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS LAST		HIGH-LEVEL PLAN	MID	LEVEL PLAN		
On the effective date of this contract, do you or your spouse have coverage through another MEDICAL HEALTH PLAN? Yes _No	PLEASE					
On the effective date of this contract, do you or your spouse have coverage through another MEDICAL HEALTH PLAN? _Yes _No		FIRST		(HUSBAND, WIFE,	SECURITY	MEMBER
				SON, OR BREGITER)	"	DIGRADELD
EMPLOYER STATEMENT: Work Status:Full-timePart-timeOn LeaveRetired (date) Date of Employment: Dental Effective Date: Termination Date:	YesNo	Carrier nolder ract Family Contract et, do you or your spouse hav Carrier nolder	re coverage through	another DENTAL	_	
EMPLOYER STATEMENT: Work Status: Full-time Part-time On Leave Retired (date) Date of Employment: Dental Effective Date: Termination Date:	The above information is true and comployer immediately.	rrect to the best of my knowled	lge. If any informati	ion pertaining to this	application changes, I w	ill notify my
Date of Employment: Dental Effective Date: Termination Date:	SIGNATURE			DATE		
	EMPLOYER STATEMENT: Work	s Status:Full-time	Part-time	On Leave	Retired (date)	
	Date of Employment:	Dental Effective I	Date:		Termination Date:	