CASEBP

DENTAL PLAN

MEMBERSHIP APPLICATION

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

PLEASE INDICATE: NEW ADDITION_____ EXISTING SUBSCRIBER_____ TERMINATION_____

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	C/O		COUNTY
CITY	STATE	ZIP CODE	PHONE #
SEX __MALE __FEMALE	DATE OF BIRTH MO DAY YR	MARITAL STATUS __SINGLE __MARRIED	MARRIAGE DATE MO DAY YR
NAME OF EMPLOYER Stamford Central School			EMPLOYMENT DATE
ADDRESS OF EMPLOYER 1 River Street Stamford, NY 12167		FEDERAL MEDICARE CLAIM NUMBER: __MEDICARE PART A EFFEC. DATE_____ __MEDICARE PART B EFFEC. DATE_____	

Check desired coverage: __INDIVIDUAL __2-PERSON __FAMILY

__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 NAME	FIRST	DATE OF BIRTH MO DAY YR	RELATIONSHIP (HUSBAND, WIFE, SON, OR DAUGHTER)	SOCIAL SECURITY #	IS MEMBER DISABLED

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_____
Individual Contract_____ Family Contract_____

On the effective date of this contract, do you or your spouse have coverage through another **DENTAL PLAN**?

__Yes __No **If yes**, indicate Carrier_____
Name of Policyholder_____
Individual Contract_____ Family Contract_____

The above information is true and correct to the best of my knowledge. If any information pertaining to this application changes, I will notify my employer immediately.

SIGNATURE_____ DATE_____

EMPLOYER STATEMENT: Work Status: ___Full-time ___Part-time ___On Leave ___Retired (date) _____

Date of Employment: _____ Dental Effective Date: _____ Termination Date: _____

Employer Representative: _____ Date: _____