

# CASEBP MEDICAL PLAN

# MEMBERSHIP APPLICATION

Check One:  NEW ENROLLMENT  CHANGE OF ENROLLMENT  TERMINATION

District: Edmeston Central School SS# \_\_\_\_\_

Employee Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Check Plan** (if multiple offered):

Plan:  L  U  PPO A

**Check Coverage Type (All that apply):**

Individual  Family  Over 65  COBRA

**Marital Status:**  Married  Single  Divorced  Widowed  Separated Date of Marriage: \_\_\_\_\_ Date of Divorce: \_\_\_\_\_

Spouse's Name (if Enrolling): \_\_\_\_\_ SS#: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Other Medical Insurance:  Yes  No

**Dependents**

Name	SS#	Date of Birth	Relationship	Handicapped	Other Medical Insurance
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

You **MUST** complete this section if you or your spouse/dependents will be covered by another medical insurance.

Are you or your spouse/dependents covered under another Medical Insurance Plan?  Yes  No

If yes, Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_  Family  Individual

Spouse or Dependent Name:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

**Enrollee Statement:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of each violation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employee Declination – IRC 89:** I swear that I have been advised of the availability of the medical benefits available to me. Further I choose not to participate in these programs at this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employer Statement** Work Status:  Full-Time  Part-Time  On Leave  Retired  COBRA  
Date of Employment: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_