CASEBP
MEDICAL PLAN

MEMBERSHIP APPLICATION

Check One: ☐ NEW ENROLLMENT ☐ CHANGE OF ENROLLMENT ☐ TERMINATION

District: ONC BOCES 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: ☐ D ☐ L ☐ U

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:_____