## **CASEBP** MEDICAL PLAN

## MEMBERSHIP APPLICATION

District: Unatego Central School       SS#	MEDICAL I LAN			
Employee       Birth Date:       Sex:         Mailing Address:	Check One:  □ NEW ENRO	LLMENT    CHANGE	OF ENROLLMENT	□ TERMINATION
Name       State       Zip Code         Italing Address:	District: Unatego Central Schoo	1	SS#	
Mailing Address:				
City:	Name:		Birth Date:	Sex:
Phas:       PPO A       Individual Panily COVETOS COBRA         Marial Status:       (Mariad Status:       (Mariad Status:       (Mariad Status:       Date of Divorce:	Mailing Address:			
Email Address:       Check Coverage Type (All that apply):         Plan: ¬PROA       ¬ladividual ¬Pamily ¬Over65 ¬COBRA         Marital Status:       Universed UNidowed USeparated Date of Marriage:	City:		State:	Zip Code:
Check Plan:       Check Coverage Type (All that apply):         Plan: DPO A       □ Endividual □ Family □ Over 65 □ COBRA         Marital Status:       □ Date of Divorce:	Home Phone:	Cell Phone:		Work Phone:
Plan:       DA       individual       Date of Diverces       Date of Diverces         Spouse's Name       SS#       Spouse's Date of Birth:       Date of Diverces       Dote of Birth:         Dependents       SS#       Date of Birth       Relationship       Handicapped       Other Medical Insurance:       Yes<	Email Address:			
Spouse's Numeuranematic       SS#:       Spouse's Date of Birth:         Emplover:       Other Medical Insurance: □ Yes □ No         Name       SS#       Date of Birth       Relationship       Handicapped       Other Medical Insurance         1	Check Plan: Plan: □ PPO A			
Employer:       Other Medical Insurance:       Yes       No         Name       SS#       Date of Birth       Relationship       Handicapped       Other Medical Insurance         1	Marital Status:  Married  Single	Divorced □Widowed □Separated	Date of Marriage:	Date of Divorce:
Dependents         Name       S8#       Date of Birth       Relationship       Handicapped       Other Medical Insurance         1	Spouse's Name(If Enrolling):	SS#:		Spouse's Date of Birth:
Name       SS#       Date of Birth       Relationship       Handicapped       Other Medical Insurana         1.	Employer:			Other Medical Insurance:  D Yes D No
2	-	SS# Dat	e of Birth Relations	hip Handicapped Other Medical Insurance
3.	1			
4.	2.			
4.	2			
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:	3			
Are you or your spouse/dependents covered under another Medical Insurance Plan?       Yes       No         If yes, Company Name:	4			
Are you or your spouse/dependents covered under another Medical Insurance Plan?       Yes       No         If yes, Company Name:	5.			
If yes, Company Name:	You <b>MUST</b> complete this section if you	or your spouse/dependents will be c	overed by another medica	al insurance.
If yes, Company Name:			-	
Address:				
Spouse or Dependent Name:       2				
Spouse or Dependent Name:       2	Effective Date of Coverage:	□ Family □ Indiv	idual	
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 participa in these programs at this time.         Signature:       Date:         Employee Statement       Work Status:       Full-Time       On Leave       Retired       COBRA         Date of Employment:       Effective Date:       Termination Date:       Termination Date:		·		
34			2.	
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:				
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Employer Statement       Work Status:       □ Full-Time       □ Part-Time       □ On Leave       □ Retired       □ COBRA         Date of Employment:        Effective Date:        Termination Date:		ar that I have been advised of the avail	ability of the medical ber	nefits available to me. Further I choose not to participate
Date of Employment:     Effective Date:     Termination Date:	Signature:			Date:
Date of Employment:     Effective Date:     Termination Date:	Employer Statement Work Status:	□ Full-Time □ Part-Time	□ On Leave □ Retir	ed 🗆 COBRA
Employer Representative: Date:		Effective Date:		
	Employer Representative:			Date: