CASEBP MEDICAL PLAN

MEMBERSHIP APPLICATION

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

District: Worcester Central School SS#________________

Employee Name:________________ Birth Date:________________ Sex:________________

Mailing Address:________________

City:________________ State:________________ Zip Code:________________

Home Phone:________________ Cell Phone:________________ Work Phone:________________

Email Address:________________

Check Plan:
Plan: □ N

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:________________