STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

APPLICATION AND POLICY CHANGE

(Please Use Ball Point Pen) EFFECTIVE DATE _____

ENROLLEE: ☐ POLICY CHANGE ☐ NEW ENROLLEE

LAST NAME | FIRST NAME | MI

Street Address | City | State | Zip Code | Phone Number

Employee Date of Birth MO DAY YR | Sex ☐M ☐F | Employee Social Security Number | Marital Status ☐Single ☐Married ☐Divorced ☐Widowed | Date Married MO DAY YR

Employer Company Name | Date of Hire- MO DAY YR Full Time | Job Title

HEALTH INSURANCE DESIRED:

MEDICAL MUTUAL- TRADITIONAL (80/20)	SUPERMED PLUS - PPO (90/10)	AULTCARE - PPO (90/10)
Group # _____	Group # _____	Group # _____
HEALTH ☐Single ☐Family	☐ HEALTH ☐Single ☐Family	HEALTH ☐Single ☐Family
DENTAL ☐Single ☐Family	☐ DENTAL ☐Single ☐Family	DENTAL ☐Single ☐Family
VISION ☐Single ☐Family	☐ VISION ☐Single ☐Family	VISION ☐Single ☐Family

RELATIONSHIP *	BIRTHPLACE Mo Day Yr	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOCIAL SECURITY NO.	OVER AGE DEPENDENT STATUS FULL TIME STUDENT	HANDICAPPED
SPOUSE		☐M ☐F					
☐Child ☐Adopted ☐Stepchild ☐Other		☐M ☐F					
☐Child ☐Adopted ☐Stepchild ☐Other		☐M ☐F					
☐Child ☐Adopted ☐Stepchild ☐Other		☐M ☐F					
☐Child ☐Adopted ☐Stepchild ☐Other		☐M ☐F					

* LEGAL DOCUMENTATION (COURT DECREE, GUARDIANSHIP PAPERS, ETC.) MUST BE ATTACHED TO THIS APPLICATION IF RELATIONSHIP IS MARKED OTHER.

CHANGES:

ADD DEPENDENTS DUE TO:
☐Marriage ☐Birth ☐Adoption

DROP DEPENDENTS DUE TO:
☐Divorce ☐Death ☐ Other: _____

☐New Name
☐New Address
☐Change to Medicare Elig.
☐Change Coverage
☐Other _____

DATE OF EVENT MO DAY YR

COV. OR CHANGE EFF. DATE MO DAY YR

MEDICARE INFORMATION

Are you covered by Medicare? ☐YES ☐NO If Yes, Medicare #_____ Effective Date: _____ ☐Hemodialysis
Is your spouse covered by Medicare? ☐YES ☐NO If Yes, Medicare #_____ Effective Date: _____ ☐Hemodialysis

OTHER INSURANCE INFORMATION

Do you or any of your family members have other health/dental insurance? ☐YES ☐NO
If YES, employed by: _____ ☐ACTIVE ☐RETIRED
Names of Insured: _____
Names of Insurance Carrier _____
Address _____ Policy No. _____ ☐Single ☐Family
What date did your prior/current health insurance program become effective _____
(check box if no prior/current coverage)? ☐ No Coverage
What date did/will tour prior/current health insurance program terminate _____
(check box if no prior/current coverage)? ☐ No Coverage

TERMS AND CONDITIONS:

Your signature on this form will indicate your understanding that your employer will enroll you for all group health plan coverages for which you are eligible, and will constitute your authorization to your employer or any of its agents to release to all administrators, carriers, or health care coverage organizations, as applicable, the information contained on this form.

Each dependent listed on this form must be an eligible dependent in accordance with your group health care plan.

Your signature on this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare-approved organization or provider of services to release any information necessary to process a claim.

Signature: _____ Date _____

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. (OHIO REVISED CODE SECTION 3999.21)

NOTES: _____

EMPLOYER REPRESENTATIVE _____ DATE _____