CARMEL CENTRAL SCHOOL DISTRICT

ENROLLEE/MEMBER INFORMATION

For Enrollment Only
Check Type:
☐ Initial ☐ Reinstatement

Employee Primary Group: _____

Last Name _____ First Name _____ Initial ____ SSN _____ DOB _____ Sex ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number/Email _____

Marriage Date _____

COVERAGE: Type: ☐ Individual (skip to Other Coverage section) ☐ Family (fully complete form) ☐ Active ☐ Retired ☐ Surviving Spouse

When applying for other than individual coverage, list all eligible dependents. Indicate relationships by specifying choices. (If other, detail in remarks and submit legal documentation.) Complete additional family information form if space is insufficient.

Relationship	First Name	MI	Last Name	DOB	SSN	Full-Time Student	Handicapped
☐ Husband ☐ Wife							
Dependent	First Name	MI	Last Name	DOB	SSN	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	First Name	MI	Last Name	DOB	SSN	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	First Name	MI	Last Name	DOB	SSN	☐ Yes ☐ No	☐ Yes ☐ No

☐ More dependents, complete Enrollment Continuation on next page

☐ Other, complete remarks Remarks: _____

CERTIFICATE OF COVERAGE/PLAN DESCRIPTION INFORMATION

Federal regulation require that your covered dependents be notified of certain Plan provisions. You must indicate you will convey your Certificate of Coverage access to all other Plan beneficiaries, or indicate where Certificate of Coverage info is to be sent.

☐ I will convey coverage information, or ☐ send additional info to: Name _____ Email _____

Street Address _____ City _____ State _____ Zip Code _____

OTHER COVERAGE INFORMATION

Are there any other hospital, medical or group health benefits provided to you, your spouse or other dependents which furnish services or similar coverage to those you are herewith enrolling for? ☐ Yes ☐ No If yes, complete the following:

Person with other coverage:	Single	Family	ID or Group No.	Carrier Name-Address	Group/Employer Name
	☐	☐			

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AUTHORIZATION/CERTIFICATION

I understand that the Plans and coverages listed above shall be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent disclosures are punishable by law. ***(DATE, PRINT AND SIGN ORIGINAL.)***

Enrollee Signature: _____ Date

LOCAL ADMINISTRATORS - (MUST BE COMPLETED)

Enrollee's Hire Date Coverage Effective Date

I certify that I have the original of this document, signed by the Enrollee, which will be maintained in the HR Dept.

Print Name Signature: Current Date