

# 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- Full Time MO DAY YR      Job Title \_\_\_\_\_

<b>HEALTH INSURANCE DESIRED:</b>	GROUP NO. _____ <b>MEDICAL MUTUAL SERVICES</b> _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family	GROUP NO. _____ <b>SUPERMED PLUS</b> _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family	GROUP NO. _____ <b>AULTCARE</b> _____ HEALTH <input type="checkbox"/> Single <input type="checkbox"/> Family DENTAL <input type="checkbox"/> Single <input type="checkbox"/> Family VISION <input type="checkbox"/> Single <input type="checkbox"/> Family
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RELATIONSHIP*	BIRTHDATE Mo Day Yr	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOCIAL SECURITY NO.	OVER AGE DEPENDENT STATUS	
						FULL-TIME STUDENT	HANDICAPPED
SPOUSE		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					
<input type="checkbox"/> Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		<input type="checkbox"/> M <input type="checkbox"/> F					

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

**CHANGES:**       New Name       Other \_\_\_\_\_  
 New Address  
**ADD DEPENDENTS DUE TO:**       Marriage       Birth       Adoption       Change to Medicare Elig       Change Coverage

**DROP DEPENDENTS DUE TO:**       Divorce       Death       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 your 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 \_\_\_\_\_