STEUBEN AREA SCHOOLS EMPLOYEES' BENEFIT PLAN
2023-2024 GROUP ENROLLMENT FORM

Instructions on reverse side

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

1-SUBSCRIBER INFORMATION

Enrollment Type (Check the correct box) INDIVIDUAL [ ] FAMILY [ ]

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY #

STREET ADDRESS

CITY	STATE	ZIP CODE	COUNTY

SEX	MALE	[ ]	FEMALE	[ ]	BIRTH DATE	MO	DAY	YEAR
MARITAL STATUS	SINGLE	[ ]	MARRIED	[ ]	MARRIAGE DATE	MO	DAY	YEAR
EMPLOYER			EMPLOYMENT DATE	MO	DAY	YEAR	RETIRE DATE	MO / DAY / YEAR

DAY PHONE	E-MAIL ADDRESS

Do you have Medicare coverage? YES [ ] NO [ ]

If yes, reason? Check one - AGE, DISABLED or ESRD? Age [ ] Disbled [ ] ESRD [ ]

Medicare Claim #		MO	DAY	YEAR
	Medicare Part A Effective Date			
	Medicare Part B Effective Date			

Please provide all other Insurance Information

	YES		NO	
Do you currently have other Health Insurance Coverage?	YES	[ ]	NO	[ ]
If "Yes" will you continue to be covered with the additional health coverage?	YES	[ ]	NO	[ ]
Have you had other health insurance coverage in the last 60 days?	YES	[ ]	NO	[ ]

Other Insurance carrier name	Policyholder
Policy ID Number	Group Number

Other Insurance Effective Date	MO	DAY	YEAR	Other Insurance Termination Date	MO	DAY	YEAR

If coverage was (will be) terminated, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

RELEASE-You must sign and date this form to be eligible for Insurance

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, 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 the claim for each such violation.

Subscriber Signature ______________________________ **Date** ______________

TO BE COMPLETED BY GROUP INSURANCE EFFECTIVE DATE ______________ Medical ID # ______________

RX ID# ______________

Employee Status (Circle One) ACTIVE RETIRED | Retirement Date ______________ | Cobra Date: ______________

Plan (Circle one)

Single active	Family active	Single Retired No medicare	Family Retired no medicare	Fam. Retired 1 w/med	Fam. Retired 2 w/ med	Single Cobra	Family Cobra
SA	FA	SRNM	FRNM	FRW1MD	FR2WMD	SC	FC

Group Leader Signature ______________________________ Date ______________

STEUBEN AREA SCHOOLS EMPLOYEES' BENEFIT PLAN
2023 - 2024 GROUP RE-ENROLLMENT FORM

MUST BE RETURNED TO YOUR DISTRICT INSURANCE ENROLLMENT PERSON BY
______________________________ TO CONTINUE WITH COVERAGE.

If you have any questions, please contact your District Health Insurance Enrollment Specialist

Instructions for Completing the Group Re-enrollment Form are as follows:

1. **ALL** information must be provided including a **full name and complete address in** ink or printed.

2. You must provide correct Social Security Numbers and Birth Dates for you and **ALL dependents.**

MEDICARE COVERAGE

3. If you and/or your dependents have Medicare coverage you **must** provide a correct Medicare Claim Number and a copy of your **Medicare Card(s)** if you have not previously done so.

4. Provide Medicare effective dates for **Parts A and B.**

* * **RETIREES PLEASE NOTE**: YOU ***MUST*** TAKE MEDICARE PARTS **A & B** WHEN YOU ARE FIRST ELIGIBLE.

OTHER MEDICAL/PRESCRIPTION INSURANCE COVERAGE

5. If you and/or your dependents have any Other Insurance coverage that is not through your employment at this school, this informaiton must be provided along with a copy of the other insurance ID card(s)

6. Remember to Sign and Date the form.

Incomplete Information may result in a delay of your coverage until the information is received.

YOU ARE RESPONSIBLE FOR NOTIFYING YOUR DISTRICT CONTACT FOR ANY AND ALL CHANGES TO DEPENDENT COVERAGE AND/OR OTHER INSURANCE INFORMATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, informtion concerning any fact material thereto, commits a fraudulent Insurance act, which is a crime, and shall also be subject to civil penalty not to exceed $5000 and the stated value of the claim for each.

STEUBEN AREA SCHOOLS EMPLOYEES' BENEFIT PLAN

2-SPOUSE INFORMATION

LAST NAME		FIRST		INITIAL	SOCIAL SECURITY #

SEX	MALE		FEMALE		BIRTH DATE	MO	DAY	YEAR

Do you have Medicare coverage?				If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO		Age		Disbled		ESRD

Medicare Claim #		MO	DAY	YEAR
	Medicare Part A Effective Date			
	Medicare Part B Effective Date			

Please Provide all other Insurance Information

Do you have other Health Insurance Coverage?	YES		NO	
If "Yes" will you continue to be covered with the additional health coverage?	YES		NO	
Other Insurance carrier name	Policyholder			
Policy ID Number	Group Number			

Other Insurance Effective Date	MO	DAY	YEAR	Other Insurance Termination Date	MO	DAY	YEAR

If coverage was (will be) terminated, please provide a copy of your "Certificate of Coverage" from your former health Insurance carrier

3-DEPENDENT CHILDREN

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY #

SEX	MALE		FEMALE		BIRTH DATE	MO	DAY	YEAR

Do you have Medicare coverage?				If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO		Age		Disbled		ESRD

Medicare Claim #		MO	DAY	YEAR
	Medicare Part A Effective Date			
	Medicare Part B Effective Date			

Please Provide all other Insurance Information for dependents

Do you have other Health Insurance Coverage?	YES		NO	
If "Yes" will you continue to be covered with the additional health coverage?	YES		NO	
Other Insurance carrier name	Policyholder			
Policy ID Number	Group Number			

Other Insurance Effective Date	MO	DAY	YEAR	Other Insurance Termination Date	MO	DAY	YEAR

If coverage was (will be) terminated, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY #

SEX	MALE		FEMALE		BIRTH DATE	MO	DAY	YEAR

Do you have Medicare coverage?				If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO		Age		Disbled		ESRD

Medicare Claim #		MO	DAY	YEAR
	Medicare Part A Effective Date			
	Medicare Part B Effective Date			

STEUBEN AREA SCHOOLS EMPLOYEES' BENEFIT PLAN

3-DEPENDENT CHILDREN-continued

LAST NAME		FIRST		INITIAL	SOCIAL SECURITY #		
SEX	MALE		FEMALE	BIRTH DATE	MO	DAY	YEAR
Do you have Medicare coverage?			If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO	Age		Disbled	ESRD	
Medicare Claim #				MO	DAY	YEAR	
		Medicare Part A Effective Date					
		Medicare Part B Effective Date					

LAST NAME		FIRST		INITIAL	SOCIAL SECURITY #		
SEX	MALE		FEMALE	BIRTH DATE	MO	DAY	YEAR
Do you have Medicare coverage?			If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO	Age		Disbled	ESRD	
Medicare Claim #				MO	DAY	YEAR	
		Medicare Part A Effective Date					
		Medicare Part B Effective Date					

LAST NAME		FIRST		INITIAL	SOCIAL SECURITY #		
SEX	MALE		FEMALE	BIRTH DATE	MO	DAY	YEAR
Do you have Medicare coverage?			If yes, reason? Check one - AGE, DISABLED or ESRD?				
YES		NO	Age		Disbled	ESRD	
Medicare Claim #				MO	DAY	YEAR	
		Medicare Part A Effective Date					
		Medicare Part B Effective Date					