# 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					INDIVIDOAL		<u> </u>	INITIAL	SOCIAL SECURITY #				
STREET ADDRESS													
CITY						STATE	ZIP	CODE		COUNTY			
						· ·	ВІ	RTH	MO	DAY	YEAR		
SEX	MALE		FEMA	ALE			D.	ATE					
MARITAL			<b>-</b>				MAR	RRIAGE	МО	DAY	YEAR		
STATUS	ATUS SINGLE MARRIED						ATE						
EMPLOYER			EMPLOY	MENT	MO	DAY	YEAR	RETIRE	MO	DAY	YEAR		
			DAT	ſΕ	igsquare			DATE		<u></u>			
DAY PHONE E-MAIL ADDRESS													
Do you have M	edicare cover			1	If yes, reason?	Check one - /	AGE, DISA 1		RD?	ESRD DAY YEAR			
YES		NO			Age		<u> </u>	Disbled					
Medic	care Claim #			1			<u> </u>	MO	DAY	YE	∃AR		
				Medi	icare Part A Effe	ective Date				<u> </u>			
					icare Part B Effe								
			Pleas	se provi	ide all other	Insurance	Informa	tion	1		_		
Do you currentl	y have other	Health Insura	ance Covera	age?			YES		NO	<u></u>	<u> </u>		
If "Yes" will you	u continue to h	oe covered w	ith the addit	ional heal	th coverage?		YES		NO				
Have you had o	other health in	surance cove	erage in the	last 60 da	ays?		YES		NO				
Other Insurance	e carrier name	e					Policyhol	lder					
Policy ID Numb	per						Group N	umber					
Other Ins	surance	МО	DAY	YEAR	Othe	er Insurance		МО	DAY	YEAR			
Effective	e Date				Terr	mination Date	<b>)</b>				1		
		rminated, pl	ease provid	le a copy	of your "Certif	ficate of Cove	rage" fron	n your form	er health				
insurance carr													
RELEASE-You n	_		•			- See Slee on one	- !:tion for	incompanies or o	tatement of old		_		
* *			-		mpany or other pe of misleading, inf		-						
	•				a civil penalty not		• •						
such violation.													
Subscriber S	ignature							Date			-		
TO BE COMPLE	TED BY GROU	IP.	INSUR	ANCE FEE	FCTIVE DATE			Medical ID #					
TO BE COMPLETED BY GROUP INSURANCE EFFECTIVE D.								RX ID#					
Employee Status (Circle One) ACTIVE RETIRED					Retirement Date				Cobra Date:				
Plan (Circle one)													
		Single Retired No	Family Retired no	Fam. Retired 1	Fam. Retired 2		Family						
	Family active	medicare	medicare	w/med	w/ med	Single Cobra	Cobra						
SA	FA	SRNM	FRNM	FRW1MD	FR2WMD	SC	FC	J					

Date

Group Leader Signature

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

MUST BE RETURNED TO YOUR DISTRICT	Γ 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 <u>MUST</u> 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 information 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, information 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 IN	FORMATION						
LAST NAME				FIRST			INITIAL SOCIAL SECURITY			ITY#		
							Г	RTH	MO	DAY	YEAR	
SEX	MALE		] FEM	٨١٦		1		ATE	MO	DAY	TEAR	
			FEIVI	ALE					DD0		<u> </u>	
Do you have M	ledicare cover	7		1	_	Check one - /	AGE, DISA 1		RD?			
YES Medicare Clain	<u> </u> n #	NO			Age			Disbled MO	DAY	ESRD VF	<u>I</u> EAR	
								WIO	D/ (1		-7 11 (	
Medicare Part A Effective Date  Medicare Part B Effective Date												
							rmation					
Please Provide all other Insurance Info Do you have other Health Insurance Coverage?									NO		1	
If "Yes" will yo			-	ional heal	th coverage?		YES YES		NO		1	
Other Insurance			iii iiio aaaii	ionai noai	ar coverage.		Policyho	lder	110		1	
Policy ID Numb		<u> </u>					Group Number					
Other In:		МО	DAY	YEAR Other Insurance			Oroup II	MO	DAY	YEAR		
Effectiv			27.11	Termination Date			<u> </u>		2711	,	1	
		rminated, pl	ease provid	le a copy	<u> </u>			n your forme	er health Ins	urance carr	ier	
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	SOC	CIAL SECUR	ITY#	
							ВІ	RTH	MO	DAY	YEAR	
SEX	MALE		] FEM.	ΔΙΕ		]		ATE				
SEX MALE FEMALE  Do you have Medicare coverage? If yes, reason? Check of						Charle and			DD2		<u></u>	
-	ledicare cover	1		1		Check one - /	   		אטי			
YES NO					Age			Disbled		ESRD		
Medicare Claim #							I	MO	DAY	YE	EAR	
Medicare Part A Effective Date												
				Medi	care Part B Eff	ective Date						
Please Provide all other Insurance Information							•	dents	Ī		1	
Do you have of			-				YES		NO			
If "Yes" will you continue to be covered with the additional health coverage?							YES		NO		]	
Other Insurance		9					Policyholder					
Policy ID Numb		1	1	1	T		Group Number					
Other In:		MO	DAY	YEAR	4	er Insurance		MO	DAY	YEAR		
Effectiv						mination Date			4			
If coverage wa	as (Will be) te	rminated, pi	ease provid		or your "Certi	ificate of Cove	rage from	•				
LAST NAME				FIRST				INITIAL	SOC	CIAL SECUR	II Y #	
							ВІ	RTH	МО	DAY	YEAR	
SEX	MALE		FEMA	ALF				ATE				
Do you have M	•	age?			If ves_reason?	Check one - A			RD?		<u>.                                    </u>	
YES	23.50.5 55761	NO		]	Age	2	]	Disbled	· · • ·	ESRD		
Medicare Claim #								MO	DAY		I EAR	
ivieuicare Cialn	1#			Mad	care Part A Eff	octivo Data		IVIO	DAT	1 1 1	-AIX	
					care Part A Elli							

# STEUBEN AREA SCHOOLS EMPLOYEES' BENEFIT PLAN

3-DEPENDENT CHILDREN-continued										
LAST NAME			FIRST			INITIAL SO		CIAL SECURITY#		
						BIRTH	MO	DAY	YEAR	
SEX	MALE	FEM/	\LE			DATE				
Do you have Medicare coverage?								-	,	
YES	NO			Age		Disbled		ESRD		
Medicare Claim	n #					MO DAY		YEAR		
			Medi	care Part A Effe	ective Date					
			Medi	care Part B Effe	ective Date					
LAST NAME						INITIAL	SOC	CIAL SECUR	ITY#	
			FIRST			11111111		5# 12 O2 OO1 (	"	
						BIRTH	MO	DAY	YEAR	
SEX	MALE	FEM <i>A</i>	ALE			DATE	_			
Do you have Medicare coverage?  If yes, reason? Check one - AGE, DISABLED or ESRD?									.1	
YES NO				Age		Disbled		ESRD		
Medicare Claim	n #		MO	DAY	YE	AR				
		ective Date								
LAST NAME FIRST						INITIAL SOCIAL SECURITY #				
						BIRTH	MO	DAY	YEAR	
SEX	MALE	FEM/	\LE			DATE				
Do you have Medicare coverage? If yes, reason? Check one - AGE, DISABLED or ESRD?										
YES	NO			Age		Disbled		ESRD		
Medicare Claim #						MO	MO DAY YEAR		AR	
Medicare Part A Effective Date										
Medicare Part B Effective Date										