# 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 |
|---|---|---|
| | | |

| **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 ____________