ENROLLMENT FORM
SANDUSKY CITY SCHOOLS

SECTION I -- General Information

This is an: ☐ Initial Form ☐ Amended Form ☐ Rehire of Employee ☐ Open Enrollment

Union Membership: _____

Job Classification: ☐ Teacher ☐ Classified ☐ Administration

Building Location: _____

If amended form, indicate nature of change:

☐ Cancel ☐ Change to Other Health Insurance

☐ Retired ☐ COBRA ☐ Name Change ☐ Change of Address

☐ Drop Dependent Due to: ☐ Divorce ☐ Death ☐ Other

☐ Add Dependents Due to: ☐ Marriage ☐ Birth ☐ Adoption ☐ Other

☐ Premium Conversion ☐ Other -- Describe _____

SECTION II -- Employee Information

Employee Last Name:	First Name:	Middle Initial:	☐ Male ☐ Female	Date of Birth: / / Mo/Day/Yr
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Effective Date: / / Mo/Day/Yr	Employment Date: / / Mo/Day/Yr	Employee S.S.#:	

Employee Street Address _____ Home Phone ( ) _____

City _____ County _____ State _____ Zip Code _____ Work Phone ( ) _____

SECTION III -- Other Health Insurance

Do you or any of your family members have other health/dental insurance? ☐ YES ☐ NO

If YES, indicate type of coverage: Medical ___ Dental ___ Vision ___ Drug___ ☐ Single or ☐ Family policy Effective Date: _____

Name of individuals covered: _____

Name of other insurance carrier(s): _____

Address: _____ Policy No. _____

Are you covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. _____ Eff. Date _____

Is your spouse covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. _____ Eff. Date _____

SECTION IV – Mandatory Spouses Coverage

If your spouse is employed and has group medical and/or prescription drug benefits available through his/her employer, he/she is required to participate in his/her employer's plan. Failure to do so can result in the loss of benefits under the Sandusky Benefit Plan. I agree to permit the Health Benefit Board to contact my spouse's employer to verify this information.

Is your spouse employed? ☐ YES ☐ NO If YES, employed by: _____

Employer Street Address: _____ City _____ State _____ Zip Code _____

Does employer offer health insurance? ☐ YES ☐ NO

SECTION V -- Health Insurance Plans

	Coverage for Myself			Coverage for My Eligible Dependents		
	I Do Want Coverage for Myself	I Do Not Want Coverage because: I am covered Under my Spouse's Plan	Other Reasons	I Do Want Coverage for my eligible dependents listed in Section V	I Do Not Want Coverage for my eligible dependents because: They are covered under my Spouse's Plan	Other Reasons
A. SuperMed Plus Medical	☐	☐	☐	☐	☐	☐
B. Dental	☐	☐	☐	☐	☐	☐
C. Vision Plan	☐	☐	☐	☐	☐	☐
D. Prescription Drug	☐	☐	☐	☐	☐	☐

SECTION VI – Dependents

Names (Last, First, Middle Initial)	Birthdate (Mo/Day/Yr)	Sex M/F	Social Security Number	Over Age Dependent Status
Spouse				
Child				Full time Student Disabled
Child				Full time Student Disabled
Child				Full time Student Disabled
Child				Full time Student Disabled
Child				Full time Student Disabled
Child				Full time Student Disabled

SECTION VII – Premium Conversion

☐ Yes, I hereby authorize my employer to reduce my cash compensation each pay period to pay for my group health benefits with pre-tax dollars during the period of this election.

☐ No, I elect to pay for my group health benefits with taxable dollars for the period of this election.

☐ No, either I do not participate in the Sandusky City Schools group health plan or I am not required to contribute toward the cost of my group health benefits.

Waiver Instructions: If you have declined any coverage offered by your employer for yourself or your dependents, you must complete separate waiver form. If you decline medical coverage for you and your family because you have provided documentation showing that yo are covered by your spouse's plan, you must provide documentation showing that you are covered by your spouses plan if benefits ar provided at no cost to you.

Authorization: I hereby authorize any provider, insurance company, employer or organization to release any information regarding an health treatment or benefits payable, including disability or employment related information to the plan administrator or its authorized agen for the purpose of validating and determining benefit payable under this plan. • I understand that payments will be made directly to th provider. • A photocopy of this authorization shall be considered as effective and valid as the original. • I certify that this foregoin information is true and correct.

_____ / / _____ _____ / / _____

Employee's Signature Date Verified by School Administrator Date

COPIES (WHITE) TARASCO, INC. (YELLOW) SCHOOL ADMINISTRATOR (PINK) EMPLOYEE 2/200