DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

Employer Use Only

SECTION 1

Your Last Name	First	M.I	Your Social Security No.	Group Name: Fallsburg School District
Address			☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Domestic Partner	Group No. / Employee Code
City	State	Zip Code	Date of Marriage / / Date Of Divorce / /	Effective Date Requested
Employment Status: ☐Full-time ☐Part-time ☐Active ☐ Retired ☐COBRA Date Of Employment / / Date Of Retirement / /			Phone No. ( ) - ( ) -	

R&K Use Only

Employee No.	Billing Class	Group Code

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)

☐ Change Coverage to: (check new coverage)

☐ Cancel Coverage: (check those that apply)

☐ Add or Delete Dependent: (complete section 4)

☐ Change Enrollee's information: (complete Section 1 with new information)

Reason :

Group#	Plan	IND	2PER	FAM	MCARE
	Healthy Adv PPO	☐	☐	☐	☐
84L	EPO - 20				
84B	Alt PPO				
	HMO	☐	☐	☐	☐
	Dental	☐	☐	☐	☐
	Vision	☐	☐	☐	☐

SECTION 3

Other Coverage? Is there Coverage Under any other group health plan available to you or any member of your family ☐ **NO** ☐ **Yes**

If Yes; Policyholder Name	Relationship ☐ Self ☐Spouse ☐ Child
Social Security Number - -	Birthdate / /
Insurance Company Name	Policy Number
Address	

Plan Type: ☐Self only ☐Self and Family
Coverage Type: ☐Health ☐Drug ☐Dental ☐Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS — COPY OF MEDICARE CARD REQUIRED

ADD	DEL	RELATION-SHIP	NAME (LAST FIRST M.I.)	Birthdate (mo/day/yr)	Social Security #	Medicare A&B Effective Date
		☐M ☐F	SELF			A B
		☐ Husband ☐ Wife ☐ Domestic Partner				A B
		☐ Son ☐Daughter				A B
		☐ Son ☐Daughter				A B
		☐ Son ☐Daughter				A B
		☐ Son ☐Daughter				A B

SECT. 5

Do you have a disabled dependent beyond age 26?

☐No ☐Yes List Name(s):

Full-time college student information if applicable to coverage

List name(s): School Name and Address Expected Graduation:

Applicants Signature: Date: | Adult Dependent Signature: Date: |Employer's Signature:

GENERAL AUTHORIZATION

All information furnished heron is true and complete to the best of my knowledge. 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 five thousand dollars and the stated value of the claim for each violation. I hereby authorize my employer to make any required payroll deductions.

ADDITIONAL AUTHORIZATION FOR APPLICANTS

For Empire PPO/EPO and HMO Carriers:

BASIC COVERAGE AGREEMENT:

I certify that I am an employee or dependent of an employee of the group, a retiree of the group or a former qualified group member who is electing continuation of coverage under COBRA or New York State Continuation of coverage legislation. I hereby elect the coverage offered by my group of the type checked. If this election form is for a family or husband/wife or parent/child(ren) contract, the name of my spouse and eligible dependent children are listed, I make this request on their behalf as well as my own. I understand that I am under a continuing obligation to notify the group of a change in my or my dependents' status, and that such a change may result in a change of insurance status with the carrier. Failure to provide such notification may result in cancellation of the coverage issued by the carrier.

I authorize any health care provider, payor of health and health related claims, government agency or dentist to furnish to the carrier or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I also authorize the carrier to disclose such information to my PCP and other network physician(s), to another payer of self-insurer and to the group contract holder or anycarrrier designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits. This authorization shall become effective immediately, and shall remain in effect for six years after the termination of coverage, or the last determination or payment by the carrier on a claim or service under the coverage, whichever is latest. This authorization shall be binding upon me, my dependents, my heirs, executors, or administrators.

MEDICARE-RELATED COVERAGE AGREEMENT:

Medicare-related or Carveout coverage will be issued, as appropriate depending on the terms of your coverage, to persons eligible for Medicare when the group notifies the carrier that an individual is no longer eligible for primary coverage under the group's health benefits plan. Medicare-related coverage is designed to supplement Medicare by covering some hospital, medical, surgical services partially covered by Medicare. Carveout coverage provides the group's benefits, less the benefits available from Medicare.