



**benetech**<sup>®</sup>  
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 North Greenbush, NY 12198-0348  
 Acting as Agent of Record

# COMPLETE THIS FORM AND RETURN TO PAYROLL

## EMPLOYEE BENEFITS ENROLLMENT FORM Non-Instructional

		GROUP NAME <b>North Colonie Central School District</b>						<b>FOR OFFICE USE ONLY</b>					
<b>1. EMPLOYEE</b>	LAST NAME	FIRST NAME	M.I.	BIRTH DATE	SEX	SOCIAL SECURITY NO.				HEALTH	Coverage	Deductions	
	MAILING ADDRESS			CITY	STATE	ZIP CODE	EMPLOYMENT DATE	RETIREMENT DATE	PHONE NUMBER	LIFE			
	EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COBRA <input type="checkbox"/> SURVIVOR <input type="checkbox"/> RETIRED <input type="checkbox"/> ON LEAVE <input type="checkbox"/> TERMINATED <input type="checkbox"/> DECEASED						MARRIAGE DATE		MARITAL STATUS M - Married D - Divorced S - Single W - Widowed L - Legally Separated			SALARY	
											DENTAL	N/A	

<b>2. CARRIER INFORMATION</b>	<input type="checkbox"/> New Enrollment/Reinstatement <input type="checkbox"/> Change Coverage to: (check new coverage) <input type="checkbox"/> Cancel Coverage: (check those that apply) <input type="checkbox"/> Add or Delete Dependent: <input type="checkbox"/> Change Enrollee's Information as follows:		PLAN		IND	2/PER	FAM	MDCR	EFFECTIVE DATES	<b>3. OTHER COVERAGE</b>	<b>IS THERE ANY OTHER GROUP COVERAGE AVAILABLE TO YOU OR A MEMBER OF YOUR FAMILY?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> CDPHP <input type="checkbox"/> MVP <input type="checkbox"/> NYSHIP		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			If yes: Policyholder name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
			MET LIFE		<input type="checkbox"/>	N/A	N/A	N/A			Social Security Number: _____ Dates: ____/____/____		
			CSEA Dental		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			Insured Co. Name: _____ Policy # _____		
		<b>BENEFICIARIES:</b> Primary _____ Relationship _____ Social Security # _____ Address _____ Secondary _____ Relationship _____ Social Security # _____ Address _____										Address: _____ Plan Type: <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Family Coverage Type: <input type="checkbox"/> Hospital <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

<b>4. DEPENDENT INFORMATION</b>	LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS										* Attach copy of medicare card			5. FOR HMO OR POS ONLY		
	A D	E M P L O Y E E D	Relation- ship	Check all that apply	Last	First	M.I.	Birthdate (mo/day/yr)	Full Time student	Social Security #	Medicare A & B Effective Date *	Primary Care Physician (PCP) - OB/GYN Complete if adding/changing to CDPHP or MVP		Existing Patient		
	<input type="checkbox"/>	<input type="checkbox"/>	<b>SELF</b> <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life				____/____/____		____-____-____	____/____/____	PCP # _____ Name: _____				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife	<input type="checkbox"/> Health <input type="checkbox"/> Dental				____/____/____		____-____-____	____/____/____	PCP # _____ Name: _____				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Health <input type="checkbox"/> Dental				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____-____-____	____/____/____	PCP # _____ Name: _____				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Health <input type="checkbox"/> Dental				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____-____-____	____/____/____	PCP # _____ Name: _____				
Full-time college students age 19 and over: Name: _____ School Name and Address _____ Expected Graduation _____ Name: _____ School Name and Address _____ Expected Graduation _____											Do you have a disabled dependent beyond age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No (list name) Name: _____ Name: _____					

**AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM. (ALL ADULTS AGE 19 & OVER MUST SIGN)**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Adult Dependent Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Accepted by Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Transmitted by Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT**

**Failure to complete any sections will result in a processing delay of your application, member ID cards and claims payment. Failure by your employer to complete the employer section will also result in a delay.**

**AUTHORIZATION**

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 such violation.

On behalf of myself and any dependents listed, I hereby apply for coverage under the group contract issued to my employer.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Group Contract and any attached riders. I further understand that for HMO benefits provided, except for emergencies, covered services must be obtained through a participating physician (unless otherwise noted in a rider) or in a participating hospital (unless otherwise noted in rider) when admitted or referred by a participating physician (unless otherwise noted in rider), and also that certain services may require a co-payment (unless otherwise noted in rider) by me (or my dependents) directly to the provider of such services.

I authorize my employer to deduct the necessary premiums, if any, from my wages or salary, with the understanding that the employer acts as my agent in all dealings with my health insurance carrier, and that all acts performed by the employer and all notices given to the employer in such dealings are binding upon me, and not prohibited by statute or regulation.

I understand that unresolved grievances are subject to the procedure specified in the Group Contract.

I hereby authorize any person or institution who shall have rendered services to me or to any member of my family unit under any coverage issued, to make available, upon request, any photographs, records or information regarding services, including any mental health, alcoholism and/or substance abuse treatment records and any confidential HIV related information, to such an extent as may be reasonable to enable a health insurance carrier to provide services under the Group Contract. This authorization to disclose medical information shall remain in effect until revoked by me in writing and may be revoked at any time except to the extent that a carrier has already acted in reliance on it. If not previously revoked by me, this authorization will terminate upon termination of my participation in the Group Contract.

I hereby represent to you that all information furnished by me hereon is true and complete to the best of my knowledge.