

**COMPLETE THIS FORM AND RETURN TO PAYROLL**

**benetech**  
 One Dodge Street  
 P.O. Box 348  
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 Acting as Agent of Record

**EMPLOYEE BENEFITS ENROLLMENT FORM**  
 Teachers Aides

**1. EMPLOYEE**

GROUP NAME: **North Colonie Central School District**

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ M.I.: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ EMPLOYMENT DATE: \_\_\_\_\_ RETIREMENT DATE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

EMPLOYMENT STATUS:  ACTIVE  COBRA  SURVIVOR  RETIRED  ON LEAVE  TERMINATED  DECEASED

MARRIAGE DATE: \_\_\_\_\_

MARITAL STATUS: M - Married, D - Divorced, S - Single, W - Widowed, L - Legally Separated

HEALTH Coverage Deductions \_\_\_\_\_

LIFE \_\_\_\_\_

SALARY \_\_\_\_\_

**2. CARRIER INFORMATION**

New Enrollment/Reinstatement  
 Change Coverage to: (check new coverage)  
 Cancel Coverage: (check those that apply)  
 Add or Delete Dependent:  
 Change Enrollee's Information as follows:

Change employment status only

**3. OTHER COVERAGE**

IS THERE ANY OTHER GROUP COVERAGE AVAILABLE TO YOU OR A MEMBER OF YOUR FAMILY?  Yes  No

If yes: Policyholder name:  Self  Spouse  Child

Social Security Number: \_\_\_\_\_ Dates: / /

Insured Co. Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_

Plan Type:  Self Only  Self and Family

Coverage Type:  Hospital  Drug  Dental  Vision

**4. DEPENDENT INFORMATION**

Full-time college students age 19 and over:

Name: \_\_\_\_\_ School Name and Address: \_\_\_\_\_ Expected Graduation: \_\_\_\_\_

Name: \_\_\_\_\_ School Name and Address: \_\_\_\_\_ Expected Graduation: \_\_\_\_\_

**5. FOR HMO OR POS ONLY**

Primary Care Physician (PCP) - OB/GYN  
 Complete it adding/changing to CDPHP or MVP

Relationship	Check all that apply	Last	Name	First	M.I.	Birthdate (mm/dd/yyyy)	Full Time student	Social Security #	Medicare A & B Effective Date *	PCP #	OB/GYN #	OB/GYN #	PCP #	OB/GYN #	PCP #	OB/GYN #	PCP #	OB/GYN #	Existing Patient
<input type="checkbox"/> SELF	<input type="checkbox"/> Health <input type="checkbox"/> Health						<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Health <input type="checkbox"/> Health						<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	<input type="checkbox"/> Health <input type="checkbox"/> Health						<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Health <input type="checkbox"/> Health						<input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Health <input type="checkbox"/> Health						<input type="checkbox"/> Yes <input type="checkbox"/> No												

Do you have a disabled dependent beyond age 19?  Yes  No (list 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: \_\_\_\_\_

Accepted by Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Transmitted by Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only