

# STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

## APPLICATION/POLICY CHANGE/TERMINATION

(Please use Blue or Black Ink Only)

**ENROLLEE:** Policy Change  New Enrollee  Termination  **EFFECTIVE DATE:** \_\_\_\_\_

Employee's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

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Hire Date (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female Employee's Social Security # \_\_\_\_\_

Employee Date of Birth (m/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed  
 Date Married: (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE DESIRED:**

**HEALTH** **DENTAL —418470** \_\_\_\_\_

SUPERMED PLUS PPO —418470- \_\_\_\_\_  Single  Family  Single  Family

AULTCARE PPO—21804M - \_\_\_\_\_  Single  Family **VISION—418470** \_\_\_\_\_

BRONZE PLAN—418470- \_\_\_\_\_  Single  Family  Single  Family

**CHANGES:** Name(s) of Member/Dependents to be Changed/Added/Termed \_\_\_\_\_

ADD DUE TO: Marriage  Birth  Adoption  Date of \_\_\_\_\_

TERMINATE DUE TO: Divorce  Left Employ  Ineligible  Request Cancel  Death  Death

Relationship	Birthdate		Sex	Last Name	First Name	Social Security #	Over Age Status		
Child/ Spouse	Mo/Day/Yr	M/F	M/F	(Only if Different)			Full-Time**	Student	Disabled
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

\*\*Completed Adult Dependent Certification Form required for dependent child between 19 and 26 for Dental and/or Vision coverage.

**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: \_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_

Address \_\_\_\_\_ Policy No. \_\_\_\_\_  Single  Family

When did this insurance become effective? \_\_\_\_\_

**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, carrier, 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 \_\_\_\_\_

Employer Representative \_\_\_\_\_ Date \_\_\_\_\_ Notes: \_\_\_\_\_