STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS - RITTMAN EX VILLAGE SCHOOL DISTRICT

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

____

Street Address City State Zip Code Phone

____

Employee Date of Birth Sex Employee Social Security # Marital Status Date Married

MO DAY YR M ___ F___ ______________________ ___Single ___Married MO DAY YR

____/______/______ ___Divorced ___Widowed ____/_____/_____

INSURANCE DESIRED:

HEALTH **DENTAL 418470-655**

SUPERMED PLUS PPO 418470—654 ____Single ____Family ______Single ____Family

AULTCARE PPO 21804M –062 ____Single ____Family

CHANGES: Name(s) of Member/Dependents to be Changed/Added/Termed____

ADD DUE TO: Marriage____ Birth____ Adoption____

TERMINATE DUE TO: Divorce____ Left Employ____ Ineligible____ Request Cancel____ Death____ Date of Death________

Relationship Child/ Spouse	Birthdate Mo/Day/Yr	Sex M/F	Last Name (Only if Different)	First Name	Social Security #	Over Age Status: 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:__________________________________