HEALTH & DENTAL BENEFIT PLAN ENROLLMENT

UMR

Poughkeepsie Public School PPSTA Teachers' Association Benefit Trust

OFFICE USE ONLY:

☐ ADMIN ☐ ESP ☐ OTHER STAFF ☐ RETIRED ☐ TEACHER

☐ RESIGNED ☐ REDUCED IN FORCE

EMPLOYMENT STATUS:

☐ ACTIVE ☐ ACTIVE (PART TIME) ☐ RETIRED

☐ DEPENDENT SURVIVOR ☐ COBRA

EFFECTIVE DATE: ___/___/_____ **HIRE DATE**: ___/___/_____

EVENT TYPE:

☐ OPEN ENROLLMENT ☐ INITIAL ENROLLMENT

☐ NEW ADD | QUALIFYING EVENT

☐ CHANGE OF STATUS ☐ CHANGE OF DEMOGRAPHIC INFORMATION

TERMINATION DATE: ___/___/_____ **NAME OF MEMBER(S) TERMINATING:** ____

☐ DIVORCED ☐ DECEASED ☐ INVOLUNTARY ☐ OVER MAXIMUM AGE ☐ PER EMPLOYEE REQUEST ☐ TRANSFER TO INDIVIDUAL COVERAGE ☐ VOLUNTARY

1. ENROLLEE INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	PHONE NUMBER

STREET ADDRESS AND APT NUMBER	CITY & STATE	ZIP CODE	SEX ☐ MALE ☐ FEMALE

MARITAL STATUS & DATE OF STATUS: ___/___/________________

☐ SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DOMESTIC PARTNERSHIP ☐ SAME SEX LEGAL SPOUSE ☐ OTHER__________

2. SPOUSE / DOMESTIC PARTNER INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER:	MEDICARE PRIMARY?
					M / F	☐ Yes ☐ No

3. DEPENDENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER:	MEDICARE PRIMARY?
					M / F	☐ Yes ☐ No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? ☐ Yes ☐ No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? ☐ Yes ☐ No
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	GENDER: M / F	MEDICARE PRIMARY? ☐ Yes ☐ No

4. OTHER INSURANCE

Do you or you other family members have other health or dental insurance coverage? ☐ Yes* ☐ No

* Carrier Name: _________________ Name(s) of family members with other insurance: ___________________________ Medical/Dental/Both?: ________________

5. AUTHORIZATION TO ENROLL IN PLAN OR WAIVE COVERAGE (check enroll or waive and approve with signature)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning 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 claims for each violation

[MEDICAL COVERAGE]	☐ ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN ☐ WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE ☐ INDIVIDUAL ☐ INDIVIDUAL+SPOUSE ☐ INDIVIDUAL + CHILD(REN) ☐ FAMILY • ENROLLEE MEDICARE PRIMARY? ☐ YES ☐ NO	***Employee Signature***
[DENTAL COVERAGE]	☐ ENROLL IN THE PPSTA BENEFIT TRUST HEALTH PLAN ☐ WAIVE PPSTA BENEFIT TRUST HEALTH COVERAGE ☐ INDIVIDUAL ☐ INDIVIDUAL+SPOUSE ☐ INDIVIDUAL + CHILD(REN) ☐ FAMILY	***Date***