HUDSON CITY SCHOOL DISTRICT

EMPLOYEE BENEFIT PROGRAM

EE INFO

COMPLETE ALL INFORMATION IN THIS SECTION

EMPLOYEE LAST NAME	FIRST	MI	SEX	BIRTHDATE	DATE EMPLOYED	HOME PHONE #
				/ /	/ /	( ) -

SOCIAL SECURITY #	HOME ADDRESS	CITY	STATE	ZIPCODE

STATUS

MARK THE APPROPRIATE BOX BELOW AND FURNISH DATE

- ☐ SINGLE
- ☐ MARRIED / /
- ☐ WIDOWED / /
- ☐ DIVORCED / /

SEE ADDITIONAL INFO ON BACK IF DIVORCED

BENEFITS

MARK THE BOX OF THE TYPE OF COVERAGE YOU ARE ENROLLING FOR

	MEDICAL	DENTAL T	DENTAL S	VISION
WAIVE BENEFITS	☐	☐	☐	☐
SINGLE	☐	☐	☐	☐ SINGLE
SINGLE + SPOUSE	☐			☐ SINGLE + 1
SINGLE+CHILD(REN)	☐			☐ FAMILY
FAMILY	☐	☐	☐	

C.O.B. INFO

IF MARRIED OR APPLYING FOR FAMILY COVERAGE COMPLETE THIS SECTION

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO

ARE YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS COVERED UNDER ANY OTHER MEDICAL/DENTAL PLAN? ☐ YES ☐ NO

IF YES, NAME OF EMPLOYER _____

IF SO NAME OF PLAN/INSURER _____

ADDRESS OF EMPLOYER _____

ADDRESS OF INSURANCE CO _____

PHONE # OF EMPLOYER

EFFECTIVE DATE OF COVERAGE

DEPENDENT INFORMATION

COMPLETE BELOW ONLY IF APPLYING FOR FAMILY COVERAGE

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	RELATIONSHIP USE KEY ON BACK	CIRCLE Y OR N FOR THESE QUESTIONS: DEPENDENT RESIDES WITH YOU?		YOUR IRS DEPENDENT?		CURRENTLY FULL TIME STUDENT?	
				/ /		SPOUSE	Y	N	Y	N	Y	N
				/ /			Y	N	Y	N	Y	N
				/ /			Y	N	Y	N	Y	N
				/ /			Y	N	Y	N	Y	N
				/ /			Y	N	Y	N	Y	N

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME.

I HEREBY AUTHORIZE AND CONSENT ANY DENTIST, PHYSICIAN, SUPPLIER, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO DISCLOSE ANY INFORMATION REGARDING THE MEDICAL/DENTAL RECORDS CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO THE PLAN ADMINISTRATOR FOR THE PURPOSE OF SUPERVISING AND MONITORING THE HEALTH PLAN(S). THIS CONSENT SHALL BE VALID UNTIL REVOKED IN WRITING BY THE EMPLOYEE. FURTHERMORE, I UNDERSTAND THAT IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS AS DEFINED BY THE PLAN. I UNDERSTAND THAT MY CURRENT COVERAGE STATUS AND ENROLLMENT ELECTIONS MAY NOT BE REVERSED UNTIL THE NEXT OPEN ENROLLMENT PERIOD; WHEREAS, IF I FAIL TO COMPLETE AN ENROLLMENT FORM DURING THE NEXT ENROLLMENT WINDOW, MY CURRENT ELECTIONS WILL AUTOMATICALLY CONTINUE.

_____ EMPLOYEE SIGNATURE

_____ DATE

TO BE COMPLETED BY YOUR EMPLOYER

EFFECTIVE DATE SECTION

NAME CHANGE ☐☐ CHG DEPENDENT STATUS REASON CHANGE DATE

RE-ENROLLMENT ☐ OPEN ENROLLEE ☐ ADDRESS CHG ☐

NEW ENROLLMENT ☐ REINSTATEMENT ☐ CANCELLATION ☐