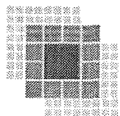

MUTUAL
HEALTH SERVICES℠

ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Change ☐ Termination ____/____/____ EFFECTIVE DATE

Reason for Change: ______________________________

EMPLOYER: KENT CITY SCHOOLS	DIVISION:
EMPLOYEE NAME: *Last, First, Middle:*	
ADDRESS: *Number & Street:*	*Apt. #:*
City: *State:* *Zip:*	*Phone:*

☐ Male ☐ Female	HIRE/REHIRE DATE:	DATE OF BIRTH:	SOCIAL SEC. #[1]:	CURRENT MARITAL STATUS ☐single ☐widowed ☐married ☐divorced	IF STATUS CHANGE: Date of change / /

[1]Social Security numbers are required for all participants (employee and dependents) of the plan. This number will not appear on your ID card.
CMS Reporting requires the plan to report this information to Medicare administration.

BENEFIT SELECTIONS

Medical/Rx Benefits:	☐ Single	☐ Family	☐ Waive (Life Only)
Dental Benefits:	☐ Single	☐ Family	☐ Waive
Vision Benefits:	☐ Single	☐ Family	☐ Waive

DEPENDENTS TO BE ENROLLED

LAST NAME, FIRST NAME, MID INIT	RELATIONSHIP[3]	SEX	BIRTH DATE	SOCIAL SECURITY #[1]	BENEFITS
Spouse:		☐M ☐F			☐M ☐D ☐V ☐Rx
[2]Child:		☐M ☐F			☐M ☐D ☐V ☐Rx
[2]Child:		☐M ☐F			☐M ☐D ☐V ☐Rx
[2]Child:		☐M ☐F			☐M ☐D ☐V ☐Rx
[2]Child:		☐M ☐F			☐M ☐D ☐V ☐Rx

[2]Proof of eligibility may be required. [3]Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify).

OTHER INSURANCE

☐ **No members of my family are covered by any other plan of insurance.**
☐ **The following members are covered by other insurance plans as noted below.**

	EMPLOYEE	SPOUSE	CHILD: ________	CHILD: ________
Policy Holder's Name:				
Insurance Company:				
Coverage Tier:	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY
Coverage Type:	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Mutual Health Services. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature of Employee ______________________________ **Date Signed** ______________

Signature of Employer ______________________________ **Date Signed** ______________

IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED
Please see the benefits office for the waiver form to complete.