ST. CLAIRSVILLE SCHOOLS
EMPLOYEE BENEFIT PLAN ENROLLMENT FORM
506-448B ADMINISTRATORS

PLEASE PRINT OR TYPE

Employee's Name_____ Soc.Sec.#_____

Address_____
Street City State Zip Code

Date of Birth_____ **Sex**_____ **Home Phone Number** (____)_____ **Occupation**_____

Are you applying for **Dental** coverage? (YES)_____ (NO)_____
If Yes, will coverage include your dependents? (YES)_____ (NO)_____

If coverage includes dependents, you *must* list and attach proof of marriage, birth, etc. Give last name of dependent if other than yours.

Name of Spouse_____ Date of Marriage _____ SS#_____ DOB_____

Name of Dep_____ Sex_____ Rel_____ SS#_____ DOB_____

Name of Dep_____ Sex_____ Rel_____ SS#_____ DOB_____

Name of Dep_____ Sex_____ Rel_____ SS#_____ DOB_____

Name of Dep_____ Sex_____ Rel_____ SS#_____ DOB_____

Do ALL covered dependents live at the same address as above? (YES) _____ (NO)_____
If NO, please provide dependent name and address: _____
If child(ren) is over age 23 - 25 and a full-time student, list child's name and name of school _____
Is your spouse employed? (YES)_____ (NO)_____ If YES, where?_____
Do you, your spouse or any dependents have other dental coverage (through Medicare or another plan)? (YES)_____ (NO)_____
If YES, list name of insurance company, type of coverage and individuals covered_____
_____

I request insurance under my Employer's Group Benefit Plan. I am actively at work the minimum number of hours required to participate in the plan.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE ACCURATE. I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE, OR ANY PERSON OR ORGANIZATION (INCLUDING MY EMPLOYER) IN POSSESSION OF INFORMATION CONCERNING INSURANCE OR OTHER BENEFITS COVERING ME OR MY DEPENDENTS, TO FURNISH TO, OR RECEIVE FROM SELF-FUNDED PLANS, INC. OR ITS AUTHORIZED REPRESENTATIVE, FULL INFORMATION REGARDING SUCH CARE OR OTHER BENEFIT INFORMATION. THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS AND I ARE ELIGIBLE TO RECEIVE BENEFITS UNDER THE PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

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Signature of Employee_____ Date Signed_____

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TO BE COMPLETED BY EMPLOYER
Date of full-time Employment_____

FOR COMPANY USE ONLY
DENTAL_____ EFF DATE_____

01/18.11