

**ST. CLAIRSVILLE SCHOOLS
EMPLOYEE BENEFIT PLAN ENROLLMENT FORM
506-448A CERTIFIED**

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.

Signature of Employee _____ Date Signed _____

TO BE COMPLETED BY EMPLOYER

Date of full-time Employment _____

FOR COMPANY USE ONLY

LIFE/AD&D _____ MEDICAL _____ DENTAL _____ DRUG _____ EFF DATE _____