RENSSELAER-COLUMBIA-GREENE HEALTH INSURANCE TRUST ENROLLMENT APPLICATION

EMPLOYER USE ONLY

Group Name

Group No. | Sub Group #

Effective Date Requested ____/____/____

SECTION 1

Your Last Name | First | M.I.

Your Social Security No. ________________

Address

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage ____/____/____ Date of Divorce ____/____/____

City | State | Zip Code

Phone No.: (____) ________

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment ____/____/____ Date of Retirement ____/____/____

SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage from __________ to __________ (check new coverage)

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information:

REASON: ____________________

Type	Plan Code(s)	Individual	2 Person	Family	Complement to Medicare
BSNENY Indemnity		❑	❑	❑	❑
BSNENY PPO		❑	❑	❑	❑
BSNENY POS		❑	❑	❑	❑
HMO		❑	❑	❑	❑
Dental		❑	❑	❑	❑
Vision		❑	❑	❑	❑
Drug		❑	❑	❑	❑

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family? ❑ No ❑ Yes

If Yes; Policyholder Name | Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number | Birthdate ____/____/____

Insurance Co. Name | Policy #

Address

Plan Type ❑ Self Only ❑ Self and Family Coverage Type ❑ Health ❑ Drug ❑ Dental ❑ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of Medicare card required

FOR HMO OR POS ENROLLMENT ONLY

ADD	DELETE	Relationship	DEPENDENT NAME Last	First	M.I	Birthdate	Full-Time Student	Social Security#	Medicare A & B Effective Date	Disabled?	Primary Physician - OB/GYN	Existing Patient ✓
❑	❑	Self ❑ M ❑ F				__/__/__		___-__-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Husband ❑ Wife				__/__/__		___-__-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-__-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-__-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-__-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	

SECT. 5

Do your dependents reside in your home? ❑ Yes ❑ No If No give address:

List names	School Name and Address	Expected Graduation

AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Applicant's Signature ____________________ Date ____________

Employer's Signature ____________________

Date ____/____/____

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