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# LAMOILLE NORTH SUPERVISORY UNION

☐ NEW ENROLLMENT ☐CHANGE OF STATUS

FORM I

***EMPLOYEE – MUST COMPLETE ALL INFORMATION IN SECTIONS 1 THROUGH 7***

## SECTION 1 – EMPLOYEE PARTICIPANT INFORMATION

| Social Security Number | Last Name ☐ check if new | First Name | MI | Date of Birth |
|---|---|---|---|---|
| Home Mailing Address ☐ check if new | City | | State | Zip Code |
| Gender ☐ Male ☐ Female | Home Phone | Work Phone | Current Marital Status ☐SINGLE ☐ MARRIED | |

## SECTION 2 – DEPENDENT INFORMTION

| | Check One | LAST NAME | FIRST NAME | MI | SEX | DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY # | Enter "Dep" Relationship Code |
|---|---|---|---|---|---|---|---|---|
| Spouse or Partner | ☐Add ☐Delete | | | | ☐M ☐F | | | |
| Dep-1 | ☐Add ☐Delete | | | | ☐M ☐F | | | |
| Dep-2 | ☐Add ☐Delete | | | | ☐M ☐F | | | |
| Dep-3 | ☐Add ☐Delete | | | | ☐M ☐F | | | |
| Dep-4 | ☐Add ☐Delete | | | | ☐M ☐F | | | |
| Dep-5 | ☐Add ☐Delete | | | | ☐M ☐F | | | |

**DEP Relationship Codes:**
**C**-Child (Birth/Adoption) **L**-Legal Guardianship* **CO**-Court Order Coverage* **SP**-Spouse
**D**-Disabled Child (attach Physician Statement **CU**- Civil Union **DP** - Domestic Partner
**S**-Stepchild***

*= Attach Court Order
*** = Who is legally responsible for stepchild(s) medical bills? ____________________

## SECTION 3 – ENROLLMENT CHOICES

☐ Elect Dental Coverage: ☐ Single ☐ Member/Spouse/Civil Union/Domestic Partner ☐ Member/1 Child ☐ Member/ 2 or more Children ☐Family
☐ Waive Coverage

## SECTION 4 - SPOUSE EMPLOYER INFORMATION

Is Spouse Employed? ☐Yes ☐ No If yes, provide Name & Address of Employer: ____________________
Does Spouse's Employer offer dental coverage? ☐ Yes ☐ No

## SECTION 5 - OTHER COVERAGE

Do you, your spouse or dependent(s) maintain other dental coverage? ☐ YES ☐ NO If Yes, complete below and provide a copy of the Plan's ID card.

| Policyholder Name | Policy Number | Group Number | Insurance Company Name & Address | Effective Date: ________ ☐Single ☐ 2P ☐ Family |
|---|---|---|---|---|
| Policyholder Name | Policy Number | Group Number | Insurance Company Name & Address | Effective Date: ________ ☐Single ☐ 2P ☐ Family |

## SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing dental insurance coverage? ☐YES ☐NO **If yes, attach a certificate of prior dental insurance coverage.** Your Prior insurer will give you this form.

## SECTION 7: SUBSCRIBER SIGNATURE

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I and any enrolled dependants agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to Comprehensive Benefits Administrator, Inc. \ Employee Benefit Plan Administration, Inc., or its designated agent for purposes of administering healthcare coverage.

| Subscriber's Signature | Date |
|---|---|
| | |

## ****EMPLOYER USE ONLY – EMPLOYER CHECK AND COMPLETE APPROPRIATE AREAS BELOW****

| | | | | |
|---|---|---|---|---|
| **COVERAGE EFFECTIVE DATES:** | Dental Effective Date: | | | |
| **EMPLOYEE STATUS:** | Date of Hire | or Full Time Status | ☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ HIPAA Qualifying Event (describe event): ____________ | |
| | Division/Subgroup **LNMUUSD 0926** _____ **CES 0927**_____ **LNSU 0930**___ | | ☐ Full-Time ☐ Part-Time ☐ Retiree | ☐ Salary ☐ Hourly - #Hours _________ |
| **REASON FOR STATUS CHANGE:** | Effective Date: | ☐ Marriage ☐ Name Change ☐ Address Change ☐ Open Enrollment ☐ Surviving Spouse ☐ Loss of Coverage (Certificate of Creditable Coverage Required) ☐ Transfer ☐ HIPAA Qualifying Event (describe event): ____________ | | |
| **CANCEL COVERAGE:** | Effective Date: | ☐ All ☐ Spouse ☐ Dependent(s) list in Section 2 | **REASON:** ☐ COBRA ☐ Divorce ☐ Retired ☐ Death ☐ Left Employment ☐ Dependent over Age ☐ Other Insurance ☐ Other describe): ____________ | |