Madison Metropolitan School District
PLEASE PRINT/COMPLETE IN FULL

Group Health Cooperative
HEALTH APPLICATION

For Retiree Open Enrollment Use Only

Applicant – Last Name	First Name	Middle Initial	FOR CARRIER USE ONLY Group #
Address – Number and Street	City-State	Zip Code	Div #/Dept

Name Change; Former Name	Work Location	Occupation	Temporary Contract? Y_____ N_____	Date Employed	Effective Date
_____					

Coverage Desired: Single (Employee Only) Family (Employee, Eligible Spouse/Partner/Children)

Marital Status: Single Married Divorced Separated Widowed

Date of occurrence _____

Phone Numbers

Home _____

Work _____

Reason for Enrollment/Change (Effective date of change) _____

Initial
Retirement (Date _____)
Add dependent (Marriage Partner Newborn Adoption Other _____)
Change to Family Coverage
Remove dependent (Name/Reason _____)
Change to Single Coverage

DOCUMENTATION REQUIRED FOR THE FOLLOWING:

Spouse's employer no longer contributing to premium Lost other coverage

Other Coverage – If you or your spouse/partner have other group health insurance, please list:

Insurance Company _____

Name of Insured _____

Group No. _____

Subscriber (Policy) No. _____

Group Name _____

I apply for the insurance under the indicated health insurance contract made available to me through the MMSD and upon the terms and conditions listed below. A copy of this application is to be considered as valid as the original.

Plan Type: HMO POS PPO (out of area residents only)

Signature _____ Date _____

SIGN BELOW IF YOU DO NOT WISH TO ENROLL

Signature _____ Date _____

Reason for not enrolling _____

_____

List ALL to be covered (PLEASE PRINT) LAST NAME FIRST NAME MIDDLE INITIAL	SOCIAL SECURITY NUMBER	BIRTHDATE Mo.	 Day	 Yr.	SEX (M/F)	SELECTED CLINIC OR PHYSICIAN (GHC COVERAGE ONLY)
Applicant						
Spouse						
Partner (registration form required)						
Your dependent children						
Other children / Relationship to you						

Have you and/or other eligible family members over 18 completed a living will or power of attorney for health? No Yes

Please name them: _____

(The Patient Self-Determination Act requires that your health insurance carrier notify your primary M.D.)

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true.
2. My remitting agent shall be the Madison Metropolitan School District.
3. I agree to apply in advance the current premium for this insurance and I authorize the remitting agent to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to the insurance carrier I have selected.
4. I agree to pay any physician, hospital, or another institution, who attends or has attended me, my spouse, partner, or any listed children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis.
5. Any children listed on this application must be unmarried and dependent on me for support and maintenance; if over the age of 25, be disabled so as to be incapable of self support.
6. Your completed and signed application must be forwarded to the Department of Human Resources so that it arrives in the Department of Human Resources within one (1) month of your date of hire, date of increased hours, or date of eligibility.

RETURN ALL COPIES TO BENEFITS