St. Lawrence-Lewis BOCES Employee Health Insurance Enrollment Form

School/Employer: SSN:

Name: Title: Date of Birth:

Address: Gender: Marital Status:

City: State: Zip Code: Reason for Enrollment:

Cell Phone: Home Phone: Work Phone: Coverage Type:

DEPENDENT LIST (Spouse, children, step-children etc...)

☐ Please use page 2 for additional dependents and check here if using page 2

Relation to Subscriber:

First Name:

Last Name:

Title: Gender: DOB:

SSN: Handicap:

Other Insurance:

Information for Dependent Children 19 or Over:

Student Status:

College/University Name:

Anticipated Graduation Date:

Relation to Subscriber:

First Name:

Last Name:

Title: Gender: DOB:

SSN: Handicap:

Other Insurance:

Information for Dependent Children 19 or Over:

Student Status:

College/University Name:

Anticipated Graduation Date:

OTHER HEALTH INSURANCE INFORMATION **(Please enter MEDICARE Information on Page 2)**

◯ Check this box if **you or any family members** had coverage under another health or dental insurance carrier during the last 63 days?

Other Carrier Name:

Other Carrier Address:

Keeping this coverage: If not, cancellation date:

Effective Date of Other Insurance:

Policy Holder's Name:

Policy Holders Insurance Number:

Type of Coverage:

Persons Covered:

Relation to Subscriber:

Other Carrier Name:

Other Carrier Address:

Keeping this coverage: If not, cancellation date:

Effective Date of Other Insurance:

Policy Holder's Name:

Policy Holders Insurance Number:

Type of Coverage:

Persons Covered:

Relation to Subscriber:

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ADDITIONAL DEPENDENTS:

Relation to Subscriber:

First Name:

Last Name:

Title: Gender: DOB:

SSN: Handicap:

Other Insurance:

Information for Dependent Children 19 or Over:

Student Status:

College/University Name:

Anticipated Graduation Date:

Relation to Subscriber:

First Name:

Last Name:

Title: Gender: DOB:

SSN: Handicap:

Other Insurance:

Information for Dependent Children 19 or Over:

Student Status:

College/University Name:

Anticipated Graduation Date:

OTHER HEALTH INSURANCE INFORMATION

Other Carrier Name:

Other Carrier Address:

Keeping this coverage: If not, cancellation date:

Effective Date of Other Insurance:

Policy Holder's Name:

Policy Holders Insurance Number:

Type of Coverage:

Persons Covered:

Relation to Subscriber:

Medicare Information Only:

Do you or your family members have Medicare coverage:

Which members currently have Medicare coverage:

Additional Family Members:

Reason for Medicare Eligibility:

Health Insurance Claim Number:

Effective Date-Medicare Part A:

Effective Date-Medicare Part B:

Spouses Employer:

ENROLLEE STATEMENT: I swear that all the above information is true and correct and that all of my health insurance coverage has been correctly indicated for both my dependents and myself.

Signature: ______________________________ Date:

Employer Statement: Full-time Part-time On Leave Retired Rider ______

Date of Employment: ____________ Effective Date: ____________ Termination Date: ____________

Employer Representative Signature: ______________________________ Date: ____________