Wright Risk Management
12 Metro Park Rd. Suite 208
Colonie, NY 12205-1139

STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

EMPLOYEE BENEFITS ENROLLMENT FORM

INSTRUCTIONS: NEW EMPLOYEE - Complete all unshaded areas and sign the form. CHANGES - Enter new or corrected information.

EMPLOYEE

SOCIAL SECURITY NO.	HOME PHONE #	ADD	CHANGE	GROUP	DIVISION
— —					

NAME (LAST, FIRST, M.I.) | ADDRESS (STREET, CITY, STATE, ZIP CODE)

BIRTH DATE	SEX	MARITAL STATUS (Married, Single, Divorced, Widow, Legally Sep.)	MARRIAGE DATE	DO YOU HAVE MEDICARE COVERAGE:	IF YES, CHECK / EFFECTIVE DATES	MEDICARE ID NO.	EMPLOYMENT DATE
/ /	M F	M S D W L		Y N	☐ Part A / / ☐ Part B / /		/ /

IN ADDITION TO THIS NEW COVERAGE WILL YOU CONTINUE TO HAVE OTHER GROUP HEALTH INSURANCE? Y N

IF YES, NAME OF OTHER CARRIER / GROUP NO.

STATUS: ☐ COBRA ☐ Active ☐ Retired ☐ On Leave ☐ Survivor ☐ Terminated ☐ Deceased

STATUS CODE | EFFECTIVE DATE / /

TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY

STATUS OF EMPLOYMENT ☐ ACTIVE ☐ RETIRED

EFFECTIVE DATE OF COVERAGE _____ / _____ / _____

SPOUSE ☐ / DOMESTIC PARTNER ☐

NAME (LAST, FIRST, M.I.)	BIRTH DATE	SEX	DISABLED	MEDICARE COVERAGE?	IF YES, CHECK / EFFECTIVE DATES	SOCIAL SECURITY NO.
	/ /	M F	Y N	Y N	☐ PART A / / ☐ PART B / /	

EMPLOYED:	IF YES, NAME OF EMPLOYER (BE SPECIFIC)	OTHER GROUP HEALTH INSURANCE:	IF YES, TYPE OF COVERAGE	EFFECTIVE DATE OF COVERAGE	STATUS OF EMPLOYMENT
Y N		Y N	☐ INDIVIDUAL ☐ FAMILY	/ /	☐ ACTIVE ☐ RETIRED

NAME OF CARRIER | ADDRESS (STREET, CITY, STATE, ZIP CODE) | PHONE NO. | GROUP NO.

REASON FOR ADDITION OR DELETION: BIRTH ☐ BIRTH DATE: ____/____/____ ADOPTION ☐ ADOPTION DATE: ____/____/____ OTHER: _____ DATE: ____/____/____

MARRIAGE ☐ MARRIAGE DATE: ____/____/____ DIVORCE ☐ DIVORCE DATE: ____/____/____ DOMESTIC PARTNERSHIP ☐ QUALIFYING DATE: ____/____/____

OTHER DEPENDENTS

RELATIONSHIP TO EMPLOYEE	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	SEX	BIRTH DATE	DISABLED	STUDENT DEP.
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N
					M F	/ /	Y N	Y N

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, ATTACH ANOTHER FORM. BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER.

BENEFIT COVERAGE

TYPE	OPTION	SINGLE FAMILY	CODE	EFFECTIVE DATE	CANCELLATION DATE
HEALTH	SWS HEALTH PLAN				

ALL INFORMATION PROVIDED HEREON IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY EMPLOYER TO MAKE ANY REQUIRED PAYROLL DEDUCTIONS.

EMPLOYEE'S SIGNATURE DATE | EMPLOYER'S REPRESENTATIVE DATE

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