J.J. STANIS AND COMPANY, INC 377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM

ENROLLMENT AND CHANGE FORM

SUFFERN CSD

Type of Coverage: (where applicable) Contribution Type: C=Contributory	Excess Major Medical		
◻ New Hire	◻ Open Enrollment	◻ Late Enrollee	◻ Rehire	Effective Date:
◻ Change Enrollment / Beneficiary	◻ New Address	◻ Name Change, previous Name:		Effective Date:
◻ Add ◻ Change ◻ Cancel Spouse/Partner and/or Dependent				Effective Date:

A. Employee Information

Name (Last, First)			Gender ◻ M ◻ F	Date of Birth:
Street Address			Date of F/T Hire	
City	State	Zip	Hours worked per week	
Social Security No.			Annual Salary $	
Job Title	Home Phone		Work Phone	
Marital Status	◻ Single ◻ Married ◻ Widowed ◻ Divorced ◻ Separated			

B. Dependent Coverage (If more space is needed, attach extra copies)

Spouse/Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		◻ M ◻ F	◻ Add ◻ Cancel	
Child's Name (Last, First)	**Date of Birth**	**Gender**	**Request to**	**Reason**
		◻ M ◻ F	◻ Add ◻ Cancel	
		◻ M ◻ F	◻ Add ◻ Cancel	
		◻ M ◻ F	◻ Add ◻ Cancel	
		◻ M ◻ F	◻ Add ◻ Cancel	

C. Beneficiaries for EMM - AD&D Benefit

◻ Add Beneficiary ◻ Change existing beneficiary to individual(s) below: (If more space is needed, attach extra copies.)

Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:				
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship
Name (Last, First)	Social Security No.	Address	Benefit %	Relationship

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

D. Participation/Waiver

◻ **Request to Participate:** I hereby request the policyholder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions from my earnings as my contributions toward the cost of insurance, if applicable.

◻ **Waiver of Insurance:** I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required to participate in the plan at a later date.

Reason for refusing:	◻ Spouse/Partner's Plan	◻ Not Interested	◻ Other, please specify:

The information provided above is true and complete to the best of my knowledge and belief.

Employee Signature:_____ **Date:**_____

Employer Representative: _____ **Date:** _____