STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS
APPLICATION and POLICY CHANGE

(Please PRINT in ink to complete)

EFFECTIVE DATE: _____

ENROLEE: _____ ☐ POLICY CHANGE ☐ NEW ENROLEE

LAST NAME	FIRST NAME	MI
Street Address	City	State / Zip Code / Phone Number
Employee Date of Birth MO / DAY / YR	Sex ☐ M ☐ F	Employee Social Security Number
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Date Married MO / DAY / YR	
Employer Company Name	Date of Hire – Full Time: MO / DAY / YR	Job Title

HEALTH INSURANCE DESIRED: SUPERMED PLUS-PRO (90/10) Group # 418470 — HEALTH ☐ Single ☐ Family
SUPERMED Plus — DENTAL ☐ Single ☐ Family
VISION ☐ Single ☐ Family

RELATIONSHIP*	BIRTHDATE MO DAY YR	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOCIAL SECURITY #	OVER AGE DEPENDENT STATUS FULL-TIME STUDENT	OVER AGE DEPENDENT STATUS HANDICAPPED
SPOUSE		☐M ☐F					
☐ Child ☐ Adopted ☐ Stepchild ☐ Other		☐M ☐F					
☐ Child ☐ Adopted ☐ Stepchild ☐ Other		☐M ☐F					
☐ Child ☐ Adopted ☐ Stepchild ☐ Other		☐M ☐F					
☐ Child ☐ Adopted ☐ Stepchild ☐ Other		☐M ☐F					

***LEGAL DOCUMENTATION (COURT DECREE, GUARDANSHIP PAPERS, ETC.) MUST BE ATTACHED IF RELATIONSHIP IS MARKED OTHER**

CHANGES

ADD DEPENDENTS DUE TO:
☐ Marriage ☐ Birth ☐ Adoption

DROP DEPENTENTS DUE TO:
☐ Divorce ☐ Death ☐ Other _____

☐ New Name
☐ New Address
☐ Change to Medicare Elig.
☐ Change Coverage

☐ Other _____

DATE OF EVENT MO / DAY / YR

COVERAGE OR CHANGE EFF. DATE MO / DAY / YR

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare #_____ Effective Date: _____ ☐Hemodialysis

Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare #_____ Effective Date: _____ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

Do you or any of your family members have other health/dental insurance? ☐ YES ☐ NO
If YES, employed by:_____ ☐ ACTIVE ☐ RETIRED
Names of Insured: _____
Names of Insurance Carrier: _____
Address _____ Policy No. _____ ☐ Single ☐ Family

What date did your prior/current health insurance program become effective?_____
(check box if no prior/current coverage) ☐ No Coverage
What date did/will your prior/current health insurance program terminate? _____
(check box if no prior/current coverage) ☐ No Coverage

TERMS AND CONDITIONS:

Your signature on this form will indicate your understanding that your employer will enroll you for all group health plan coverages for which you are eligible and will constitute your authorization to your employer or any of its agents to release to all administrators, carriers, or health care coverage organizations, as applicable, the information contained on this form.
Each dependent listed on this form must be an eligible dependent in accordance with your group health care plan.
Your signature on this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare-approved organization or provider of services to release any information necessary to process a claim.

Signature _____ Date _____

WARNING: ANY PERSON WHO, WITH INTENT TO DERAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINT AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. (OHIO REVISED CODE SECTION 3999.21)

NOTES: _____

EMPLOYER REPRESENTATIVE _____ **DATE** _____