

**TRI-COUNTY SCHOOLS INSURANCE GROUP  
ENROLLMENT AND CHANGE FORM**

EMPLOYER NAME		NEW ENROLLMENT OR CHANGE		EFFECTIVE DATE	DATE OF HIRE	Full-Time
		OPEN ENROLLMENT				Part-Time
SOCIAL SECURITY NO.	LOCATION NO.	CLASS NO.	EMPLOYEE JOB TITLE			
EMPLOYEE NAME LAST, FIRST, MI					DATE OF BIRTH	Male Female
EMPLOYEE ADDRESS City State Zip					Single Divorced	Married or DP Widowed
HOME PHONE		WORK PHONE		EMAIL ADDRESS		
SPOUSE'S EMPLOYER NAME AND ADDRESS						
IS YOUR SPOUSE ENROLLED IN ANOTHER HEALTH PLAN?		YES	IF YES, INSURANCE COMPANY NAME	PLAN NAME OR NUMBER		
		NO				

**COMPLETE THIS SECTION ONLY IF DEPENDENT COVERAGE IS ELECTED**

Please list all eligible family members to be enrolled or changed. New Enrollees must provide a copy of their marriage certificate or Certificate of Domestic Partnership when electing spousal coverage. A copy of child/children(s) birth certificates are required when electing dependent coverage.

NAME LAST, FIRST, MI	SEX		DATE OF BIRTH			SOCIAL SECURITY NO.		FULL-TIME STUDENT		STEP-CHILD		Does the step-child live with you and depend on you for support?		Other insurance coverage?	
	M	F	Month	Day	Year			Yes	No	Yes	No	Yes	No	Yes	No
Spouse															
Child															
Child															
Child															
Child															

If the answer to Other Dependent Insurance Coverage is yes, please complete the following:

Name of Policy Holder: \_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_  
 Plan Name or Number: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

COVERAGE ELECTION		ADD	CHANGE			
TYPE OF COVERAGE	PLAN NAME OR NUMBER	EMPLOYEE	SPOUSE	CHILD	EFFECTIVE DATE	
MEDICAL		Yes No	Yes No	Yes No		
DENTAL		Yes No	Yes No	Yes No		
VISION		Yes No	Yes No	Yes No		
LIFE/AD&D		Yes No				
<b>WAIVER OF BENEFITS</b>	_____ Employee's Signature		I hereby certify that the benefits provided under the Group Medical Insurance program as provided by my Employer have been explained to me. I have been given an opportunity to participate in all of the plans offered and that I voluntarily decline to do so. I understand that by refusing to participate in the plans personally, I surrender any rights I may have had to cover my dependents and myself. Should I wish to become covered at a later time, I understand that I must wait until the next open enrollment period offered by my Employer and Tri-County Schools Insurance Group.			

**BENEFICIARY INFORMATION FOR LIFE/AD&D COVERAGE:** ADD CHANGE

If the Primary Beneficiary(ies) dies before me, I designate as the Contingent Beneficiary(ies): I RESERVE the right to change this designation at any time.

<b>PRIMARY BENEFICIARY:</b> Last Name, First, MI Relationship DOB	<b>CONTINGENT BENEFICIARY:</b> Last Name, First, MI Relationship DOB
Address	Address
City State Zip	City State Zip

Unless designated otherwise, payment will be made in equal shares or all to the survivor. Indicate how benefits are to be designated (e.g., Divide equally among beneficiaries):

**PARTICIPANT DECLARATION:** I declare that the above answers are true to the best of my knowledge and I have read and understand the Participant Authorization on the back of this form. I hereby authorize my Employer to deduct from my earnings any required contributions for the cost of benefits for which I am or may become eligible.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PERSONAL HEALTH INFORMATION (PHI)

Any information provided on this Enrollment Form will only be used for communication with the Covered Person, claims processing and benefit management.

### PARTICIPANT AUTHORIZATION

I understand I am applying to Tri-County Schools Insurance Group for coverage for myself and my dependents, if any, as shown on this form. I understand any misstatements on this form may be used as a basis for rescission of benefits for me and my dependents (if any) from the effective date. I further understand that if the benefits applied for become effective, I will be subject to all the terms of the group policy(ies). I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, or other organization, employees, or other person that has any information available as to my health or that of any member of my family covered under this Plan to give Tri-County Schools Insurance Group or its legal representative any such information. A photographic copy of this authorization shall be as valid as the original.

### Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Signature

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Date