

OSSINING UNION FREE SCHOOL DISTRICT 680

Employee Benefits Enrollment

ENROLLEE

SOCIAL SECURITY NO.		ENROLLEE LAST NAME		FIRST NAME		INIT	
STREET ADDRESS							
CITY		STATE	ZIP		BIRTHDATE	SEX (M/F)	
MARRITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> LEGALLY SEPARATED		DATE OF MARRIAGE	HOME PHONE		WORK PHONE		
ARE YOU PRESENTLY EMPLOYED ELSEWHERE? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES TO EITHER OF THE TWO PRECEDING QUESTIONS PLEASE COMPLETE THE FOLLOWING ▼				
NAME OF OTHER OR PREVIOUS EMPLOYER			DO YOU HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE THRU YOUR OTHER OR PREVIOUS EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING				
TYPE OF BENEFITS		NAME OF CARRIER/ADMINISTRATOR		EFFECTIVE DATE	CANCELLATION DATE	COVERAGE	
PLEASE CHECK (✓) HEALTH <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
DENTAL <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
OTHER <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	

AGENCY		DEPT.		DIV.	
EMPLOYMENT DATE		TERMINATION DATE		RETIREMENT DATE	
SALARY CODE		UNION CODE		UNION CO. EFF. DATE	
POSITION JOB TITLE			JOB NO.		
ENROLLEE CLOCK NO.			ANNUAL SALARY		
EMPLOYMENT STATUS CHECK (✓) ONE				DATE STATUS EFF.	CODE
<input type="checkbox"/> ACTIVE/FULL TIME		<input type="checkbox"/> LEAVE OF ABSENCE		<input type="checkbox"/> TERMINATION	
<input type="checkbox"/> ACTIVE/PART TIME		<input type="checkbox"/> DISABLED		<input type="checkbox"/> COBRA	
<input type="checkbox"/> ACTIVE/TEFRA		<input type="checkbox"/> DECEASED		<input type="checkbox"/> MISCELLANEOUS	
<input type="checkbox"/> RETIRED		<input type="checkbox"/> SURVIVOR			

NEW ENROLLMENT -

Complete all unshaded areas and sign the form. If family coverage applies, please make sure both sides of the form are completed.

CHANGES -

Employee should make changes by entering corrected data below the preprinted data and sign the form. It is not necessary to complete the entire form, only those unshaded areas where current information is to be changed.

I certify that all the information is correct.

Date

Employee Signature

Date

Employer Signature

BENEFITS	TYPE	OPTION	YES/NO	SINGLE/FAMILY	CODE	EFFECTIVE DATE	CODE	CANCELLATION DATE
	HEALTH	POMCO						

THIS FORM DEVELOPED BY POMCO

SPOUSE	01	LAST NAME (IF DIFFERENT)			FIRST NAME			INIT.
	BIRTHDATE	SEX (M/F)	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE YES NO	SPOUSE SOC. SEC. NO.	
	NAME OF SPOUSE'S EMPLOYER						DOES YOUR SPOUSE HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE? <input type="checkbox"/> YES IF YES, COMPLETE THE FOLLOWING <input type="checkbox"/> NO	
	TYPE OF BENEFITS PLEASE CHECK (✓)	NAME OF CARRIER/ADMINISTRATOR			EFFECTIVE DATE	CANCELLATION DATE	COVERAGE	
	HEALTH <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
	DENTAL <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
	OTHER <input type="checkbox"/>				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
	TYPE _____				/ /	/ /	INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	

If a dependent is age 19 or over, a student certification must be completed.

OTHER DEPENDENTS	LAST NAME (IF DIFFERENT)		FIRST NAME		INIT.	BIRTHDATE	SEX M F	RELATIONSHIP TO ENROLLEE	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT SOC. SEC. NO.		NAME OF EMPLOYER/COLLEGE			EXPECTED GRADUATION DATE	
	LAST NAME (IF DIFFERENT)		FIRST NAME		INIT.	BIRTHDATE	SEX M F	RELATIONSHIP TO ENROLLEE	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT SOC. SEC. NO.		NAME OF EMPLOYER/COLLEGE			EXPECTED GRADUATION DATE	
	LAST NAME (IF DIFFERENT)		FIRST NAME		INIT.	BIRTHDATE	SEX M F	RELATIONSHIP TO ENROLLEE	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT SOC. SEC. NO.		NAME OF EMPLOYER/COLLEGE			EXPECTED GRADUATION DATE	
	LAST NAME (IF DIFFERENT)		FIRST NAME		INIT.	BIRTHDATE	SEX M F	RELATIONSHIP TO ENROLLEE	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT SOC. SEC. NO.		NAME OF EMPLOYER/COLLEGE			EXPECTED GRADUATION DATE	

If more space is needed to list dependents, please use another form. Be sure to enter your social security number on any additional forms.