

SHENENDEHOWA CENTRAL SCHOOL DISTRICT
5 Chelsea Place, Clifton Park 12065, Phone: (518) 881-0600

Rev. 2/11/09

S E C T I O N A

Your Last Name _____ M.I. _____
 First _____
 Address _____ County _____
 City _____ State _____ Zip Code _____

Your Social Security No. _____ - - - - -
 Single Married Separated Divorced Widowed
 Date of Marriage ___/___/___ Date of Divorce ___/___/___
 Phone No. (___) _____ (___) _____
 Employment Status: Full-time Part-time Active Retired COBRA
 Date of Hire ___/___/___ Date of Retirement ___/___/___

EMPLOYER USE ONLY
 Effective Date ___/___/___
EMPIRE HEALTH 991808
 991808-A
 991808-2
CDPHP HMO 15
MVP COC 15
EMPIRE Rx 991808
 991808-A
 991808-2

S E C T I O N B

New enrollment/Reinstatement (complete Section D)
 Change coverage to (check new coverage)
 Cancel Coverage (check those that apply)
 Add or Delete Dependent (complete Section D)
 Change Enrollee's Information (complete Section A with new info.)

Reason: _____

EMPIRE HEALTH Ind 2P Fam Medicare
CDPHP Ind 2P Fam Medicare
MVP Ind 2P Fam Medicare
EMPIRE Rx Ind Fam Medicare

S E C T I O N C

Other Coverage?
 Is there coverage under any other group health plan available to you or any member of your family?
 No Yes
 If Yes; Policyholder Name _____ Relationship _____
 Social Security Number _____ Birth Date ___/___/___
 Insurance Co. Name and Address _____ Policy # _____
 Coverage Type Health Drug Dental Vision
 Plan Type Self only Self/Fam
 Copy of medical card required _____

L I S T A P P L I C A N T A N D A L L E L I G I B L E D E P E N D E N T S

ADD	DELETE	Relationship	DEPENDENT NAME	Birth Date (mo/day/yr)	Full-Time Student	Social Security #	Medicare A & B Effective Date	PCP - OB/GYN Practice #	Primary Physician - OB/GYN	Existing Patient
<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Husband Wife	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Son Daughter	First _____	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___	_____	PCP: _____ OB/GYN: _____	<input type="checkbox"/>

S E C T I O N D

Do your dependents reside in your home?
 Yes No If No, give address: _____
 Do you have a disabled dependent beyond age 19?
 Yes No List name(s): _____

S E C T I O N E

Full-time college students age 19 and over:
 List names: _____ School name and Address: _____
 Expected Graduation: _____

THIS FORM MUST HAVE AN ORIGINAL SIGNATURE AND BE SUBMITTED TO THE HUMAN RESOURCES DEPT IN PAPER FORMAT (NOT ELECTRONICALLY).
 Applicant's Signature: _____ Date: _____
 Employer's Signature: _____ Date: _____