

CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

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GROUP NAME _____

SECTION A	Last Name _____	First _____	M.I. _____	Your Social Security No. _____	EMPLOYER USE ONLY
	Address _____			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
	City _____ State _____ Zip Code _____			Date of Marriage ____/____/____ Date of Divorce ____/____/____ Phone No.: (____) _____ (____) _____ Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT Hrs/Weekly _____ <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA Hire Date ____/____/____ Status Chg Date ____/____/____	
Effective Date ____/____/____ Retire Date ____/____/____ Grp No. _____ Loc. Code _____					

SECTION B	<input type="checkbox"/> Open Enrollment (complete Section D) <input type="checkbox"/> New Enrollment/Reinstatement (complete Section D) <input type="checkbox"/> Change Coverage to (check new coverage) <input type="checkbox"/> Cancel Coverage (check what applies) <input type="checkbox"/> Add/Delete Dependent (complete section D) <input type="checkbox"/> Information Change (complete Section A) <input type="checkbox"/> Waive Coverage (must provide proof of Insurance) <input type="checkbox"/> NYS Dependent Coverage up to Age 29	Carrier	Tier	SECTION C	Other Coverage? Is there coverage under any other group health plan available to you or any of your covered dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Indem/Blue Shield	Ind 2P Fam Mdcr		If Yes: Policyholder Name _____ Relationship _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
		PPO/Blue Shield	Ind 2P Fam Mdcr		Social Security Number _____ Birth Date _____	
		POS/Blue Shield	Ind 2P Fam Mdcr		Insurance Co. Name _____ Policy # _____	
		CDPHP EPO	Ind 2P Fam Mdcr		Plan Type <input type="checkbox"/> Self only <input type="checkbox"/> Self/Spouse <input type="checkbox"/> Self/Child(ren) <input type="checkbox"/> Fam Coverage Type <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
		MVP HMO	Ind 2P Fam Mdcr			
		Rx	Ind 2P Fam Mdcr			
		Dental	Ind 2P Fam Mdcr			
Reason/Comments: _____		Other	Ind 2P Fam Mdcr			

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below)

ADD	DELETE	Relationship	Last	First	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date	MVP HMO & BS POS ONLY Primary Care Physician (PCP)
<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F				____/____/____	n/a	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	Spouse/DP <input type="checkbox"/> M <input type="checkbox"/> F				____/____/____	n/a	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	

SECTION E Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give address: _____ Do you have a disabled dependent beyond age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No List name(s): _____	Full-time college students age 19 and over (Dental Only): List Names: _____ School Name and Address: _____ _____ _____	Dependent Verification* School District Representative (SDR) _____ (please initial) Date: _____ * The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).
Applicant's Signature: _____ Date: _____	Employer's Signature: _____ Date: _____	