



Cortland County GROUP BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

- Attached
- Pending
- No Prior Coverage

- MANAGEMENT
- NURSES
- GENERAL CSEA
- ROAD
- CIVILIAN
- CORRECTIONS

LAST NAME: _____
 FIRST NAME: _____
 SEX: MALE FEMALE

- MARITAL STATUS:
- SINGLE
 - MARRIED
 - DIVORCED
 - LEGALLY SEPARATED

SS #: _____
 DATE OF BIRTH _____
 SPOUSE'S DATE OF BIRTH _____
 DATE OF HIRE _____
 EFFECTIVE DATE _____

- ACTIVE (PART-TIME)
- ACTIVE (FULL-TIME)
- COBRA
- RETIRED WITH OUT MEDICARE
- RETIRED WITH MEDICARE
 MEDICARE CLAIM NO. _____
 PART A EFF. DATE: _____
 PART B EFF. DATE: _____

ADDRESS: _____
 STREET _____
 CITY, STATE, ZIP _____
 COUNTY _____
 HOME PHONE _____
 BUSINESS PHONE _____

- | | |
|-------------------|--------------------------|
| COVERAGE* | MEDICAL |
| EMPLOYEE ONLY | <input type="checkbox"/> |
| EMPLOYEE & FAMILY | <input type="checkbox"/> |
| NO COVERAGE* | <input type="checkbox"/> |

*If you are single and do not wish coverage, or if you have an eligible spouse and/or dependents but do not wish to cover them, please complete a Waiver of Participation Form.

<input type="checkbox"/> Spouse	Name (First, Last)	Sex	Date of Birth	Social Security #			
<input type="checkbox"/> Children	Name (First, Last)	Relationship	Sex	Date of Birth	Social Security #	College Name	Disabled Y/N?

Spouse Information (Must Be Completed)

Is spouse employed? Yes No Medicare Eligible? Yes No Medicare Claim No. _____

Type of Coverage: Medical Dental Prescription Vision Enrolled in Group Health Plan? Yes No Part A Eff. Date: _____

Part B Eff. Date: _____

Single Family

Name, Address, and Phone # of Spouse's Employer: _____

Name, Address, and Policy Number of Other Health Insurance Coverage: _____

I AUTHORIZE PAYMENT OF BENEFITS TO ANY DOCTOR, PHYSICIAN OR OTHER PROVIDER FOR SERVICES WHICH HE/SHE MAY RENDER TO ME OR MY FAMILY. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I DESIRE TO PARTICIPATE IN THE GROUP MEDICAL PROGRAM.

DATE

SIGNATURE OF EMPLOYEE