Cortland County
GROUP BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

☐ 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 _____
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

	INDIVIDUAL	FAMILY
MEDICAL (INCLUDES PRESCRIPTION)	_____	_____
DENTAL	_____	_____
VISION	_____	_____

☐ **Spouse** Name (First, Last) Sex Date of Birth Social Security #

☐ **Children**

Name (First, Last)	Relationship	Sex	Date of Birth	Social Security #	College Name	Disabled Y/N?

Spouse Information (Only complete if enrolling spouse) Medicare Eligible? ☐ Yes ☐ No Medicare Claim No. _____
Is spouse employed? ☐ Yes ☐ No Enrolled in Group Health Plan? ☐ Yes ☐ No Part A Eff. Date: _____
Type of Coverage: Medical ☐ Dental ☐ Prescription ☐ Vision 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