Cayuga-Onondaga Area School Employees' Healthcare Plan Enrollment Form*

☐ **Traditional Plan** ☐ **Modified Traditional Plan**

☐ Cato-Meridian ☐ Cay-Onon BOCES $10/$15 (CAY) ☐ Cay-Onon BOCES 100% (CAU) ☐ Jordan-Elbridge ☐ $3/3 ☐ Moravia - RX ☐ Port Byron ☐ 100% (PTB) ☐ (POT) ☐ Port Byron- ☐ $10 (PBA) ☐ $8 (POR) ☐ Port Byron ☐ $3 (PPR) ☐ $10/$12 (PRB) ☐ Skaneateles ☐ Southern Cayuga-Rx ☐ (SOY) 100% ☐ Southern Cayuga-Rx ☐ (SOU) $10/$15 ☐ Union Springs ☐ Weedsport	Last Name _____ First Name _____ Address _____County _____ City/ State/ Zip _____ Home Business Phone _____Phone _____ SS#: _____ Sex: _____Male ____ Female Date Of Birth: _____	☐ Cato-Meridian ☐ Cay-Onon BOCES ☐ Jordan-Elbridge ☐ Moravia ☐ Port Byron ☐ Skaneateles ☐ Southern Cayuga ☐ Union Springs ☐ Weedsport

☐ Active Single ☐ Retired Single Under 65 ☐ Active Family ☐ Retired Family Under 65 ☐ Retired Single Over 65 ☐ Retired Family Both Over 65 ☐ Retired One Over 65, One Under 65 ☐ Cobra	**COVERAGE: MEDICAL** ☐ Employee Only ☐ Employee & Family ☐ No Coverage	**MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Spouse

Name (First, Last) Sex Date Of Birth Social Security #

Spouses address (if different)

Children

Name (First, Last) Relationship Sex Date Of Birth Social Security # School/College, City/State

Spouse Information (Must be completed) Medicare Eligible: ☐ Yes ☐ No

Is spouse employed: ☐ Yes ☐ No Enrolled in Group Health Plan: ☐ Yes ☐ No ☐ Single ☐ Family

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

Name, Address, and Phone # of Other Health Insurance Coverage:_____

I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, SURGEON OR PHARMACY TO RELEASE INFORMATION REQUESTED BY CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN OR ITS REPRESENTATIVES TO PROCESS CLAIMS INVOLVING ME OR MY FAMILY. I ALSO 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 MEDIAL PROGRAM AND AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION FROM MY WAGE OR SALARY TO PAY MY PART OF THE COST.

EMPLOYEE SIGNATURE_____DATE_____

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OFFICE USE ONLY	**EMPLOYER'S STATEMENT** **EFFECTIVE DATE_____HIRE DATE_____CERTIFIED BY_____**