WESTSIDE
COMMUNITY SCHOOLS
HUMAN RESOURCES

Pre-65 Enrollment/Change Form

☐ Enroll
☐ Cancel Date: ___/___/___
☐ Change
☐ Name/Address Change

Email Address:

Social Security Number	Name *(last)* *(first)*	Date of Birth ___/___/____	Gender ☐ Male ☐ Female

Address *(street, PO Box)*	City	State	Zip	Home Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

DEPENDENT INFORMATION

Last Name First Name MI	Gender	Relationship	Birth Date	Social Security Number
	n M n F	Spouse		
	n M n F	n Child n Stepchild		
	n M n F	n Child n Stepchild		
	n M n F	n Child n Stepchild		
	n M n F	n Child n Stepchild		

COVERAGE SELECTION-MEDICAL
☐ $2,500 Deductible Plan
☐ $3,800 Deductible Plan

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Family
☐ Decline Medical Coverage

COVERAGE SELECTION – DENTAL
☐ Dental

☐ Employee Only
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Family
☐ Decline Dental Coverage

CHANGE SECTION:
☐ Cancel Medical
☐ Cancel Dental

OTHER MEDICAL COVERAGE INFORMATION

On the day this coverage begins, will you, your spouse or any dependents be covered under any other medical health plan or policy, including another health plan or Medicare? ☐No (skip the rest of this section) ☐ Yes (continue completing this section)

☐ Name of Other Insurance Carrier_____
☐ Spouse's employer's plan ☐ Tri-Care
☐ Individual plan ☐ Medicare
☐ VA eligibility ☐ Medicaid
☐ COBRA ☐ I(we) have no other coverage ☐ Other_____

If Medicare: Name of Beneficiary

Medicare HIC# | Part A Effective Date: ___/___/____ | Part B Effective Date ___/___/____

Reason for entitlement (check all applicable boxes) ☐ Age ☐ Disability ☐ End stage renal disease

OTHER DENTAL COVERAGE INFORMATION

On the day this coverage begins, will you, your spouse or any dependents be covered under any other dental plan or policy?
☐ Yes (continue completing this section) ☐No (skip the rest of this section)
☐ Name of Other Insurance Carrier_____
☐ Spouse's employer's plan
☐ Individual plan
☐ I(we) have no other coverage ☐ Other_____

AGREEMENT AND AUTHORIZATION
PLEASE READ THE FOLLOWING CAREFULLY

I represent the above information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained in this enrollment form will be used to determine eligibility for coverage. I further understand that if any material information is omitted, it could provide the basis to refuse or rescind coverage.

I agree to the following terms for myself and anyone enrolled on or added to this application: We authorize, if permitted by law, health care providers, insurers, claim administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance carrier on this enrollment form or their authorized representatives. Insurance carriers or their authorized representatives may share in such information and provide it to their insurers, claim administrators, insurers or other provider organizations only for the purpose of administering group coverage and claims for benefits, utilization review, analytical or research purposes, risk management, provider peer review or the resolution of grievances. I also authorize on behalf of myself and anyone enrolled or added to this application the use of Social Security Numbers for purposes of identification. I agree that a reproduced copy of this authorization will be as valid as the original.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE
(SIGNATURE REQUIRED BELOW)

X_____ **X**_____
Signature **Date Signed**

WAIVER/DECLINE COVERAGE:

X_____ **X**_____
Signature **Date Signed**

I have been given the opportunity to apply for group health coverage for myself and my dependents (if applicable)

If you are waiving/declining coverage for yourself or your dependents (including your spouse) because of other coverage, you or your dependents will not be able to enroll in the plan at a later time.