DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

EMPLOYER USE ONLY

Group Name

Group No. | Employee Code

Effective Date Requested ____/____/____

TRUST USE ONLY

Employee No.	Billing Class	Group Code

SECTION 1

Your Last Name ______ First ______ M.I. ______

Address

City ______ State ______ Zip Code ______

Your Social Security No. [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Domestic Partner

Date of Marriage ____/____/____ Date of Divorce ____/____/____

Phone No.: (______)__________ (______)__________

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment ___/___/___ Date of Retirement ___/___/___

SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage to: (check new coverage)

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information: (complete Section 1 with new information)

REASON: ____________________

Type	Option	Individual	2-Person	Family	Complement to Medicare
Matrix		❑	❑	❑	❑
PPO		❑	❑	❑	❑
A. PPO		❑	❑	❑	❑
HMO		❑	❑	❑	❑
Dental		❑	❑	❑	❑
Vision		❑	❑	❑	❑
Misc.		❑	❑	❑	❑

Date of change: ____/____/____

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family?
❑ No ❑ Yes

If Yes; Policyholder Name ______ Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number ______ Birthdate ___/___/___

Insurance Co. Name ______ Policy #

Address

Plan Type ❑ Self Only ❑ Self and Family **Coverage Type** ❑ Health ❑ Drug ❑ Dental ❑ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

FOR HMO OR POS ENROLLMENT ONLY

ADD	DELETE	Relationship	NAME Last	First	M.I.	Birthdate (mo/day/yr)	Full-Time Student	Social Security #	Medicare A & B Effective Date	Medical Practice Number	Primary Care Physician – OB/GYN	Existing Patient ✓
❑	❑	**Self** ❑ M ❑ F				___/___/___		___-___-___	___/___/___ ___/___/___		PCP OB/GYN	
❑	❑	❑ Husband ❑ Wife ❑ Other				___/___/___		___-___-___	___/___/___ ___/___/___		PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				___/___/___	❑ Yes ❑ No	___-___-___	___/___/___ ___/___/___		PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				___/___/___	❑ Yes ❑ No	___-___-___	___/___/___ ___/___/___		PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				___/___/___	❑ Yes ❑ No	___-___-___	___/___/___ ___/___/___		PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				___/___/___	❑ Yes ❑ No	___-___-___	___/___/___ ___/___/___		PCP OB/GYN	

SECT. 5

Do your dependents reside in your home?
❑ Yes ❑ No If No give address:

Do you have a disabled dependent beyond age 19?
❑ No ❑ Yes List name(s):

Full-time college students age 19 and over:

List names	School Name and Address	Expected Graduation:

AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Applicant's Signature ____________ Date ______

Adult Dependent Signature ____________ Date ______

Adult Dependent Signature ____________ Date ______

Adult Dependent Signature ____________ Date ______

Employer's Signature ____________

Date ____/____/____