## EDCARE GROUP GROUP HEALTH PLAN ENROLLMENT FORM

O Modern Medical Plan O Bronze Medical Plan O Vision Plan (through Vision Service Plan) O Dental Plan (through Ameritas)  DEPENDENT ENROLLMENT (Complete for each eligible dependent)  SPOUSE'S EMPLOYER:  Relationship First and Last Name SSN Date of Birth group coverage?  Husband Son Son Step-child	o Male					EMPLOYEE I
Complete Address - (Street # & Name, City, State, Zip Code)  Date of Hire	o Femal					
Date of Hire		Social Security Number		MI	First Name	Last Name
FOR EMPLOYER USE ONLY:		Date of Birth			(Street # & Name, City, State, Zip Code)	Complete Address
O New Hire Date of Employment  Coverage Effective Date    Description		one Number	Phone Number		Effective Date (leave bla	Date of Hire
Date of Employment   Coverage Effective Date		Center CC	O State Ce	Fowler Unified	JSE ONLY: O Kingsburg Elementary	FOR EMPLOYER
Date of Employment   Coverage Effective Date			<sub>t</sub> h	or coverage was throug	O Change only If a change, p	O New Hire
BENEFIT ELECTION  O I elect the following coverage:  O Modern Medical Plan O Spouse O Children O Vision Plan (through Vision Service Plan) O Dental Plan (through Ameritas)  O Dental Plan (through Ameritas)  Reason:    DEPENDENT ENROLLMENT (Complete for each eligible dependent)    Reason:			,			
O I elect the following coverage: O Modern Medical Plan O Bronze Medical Plan O Usion Plan (through Vision Service Plan) O Dental Plan (through Ameritas)  DEPENDENT ENROLLMENT (Complete for each eligible dependent)  SPOUSE'S EMPLOYER:  Relationship First and Last Name SSN Date of Birth group coverage?  No Vision Plan (through Ameritas)  Print and Last Name SSN Date of Birth Birth SSN Date of Birth Proves Carrier No Vision No Vision Plan (through Ameritas)  SSN Date of Birth Proves Carrier No Vision No Carrier SPOUSE'S EMPLOYER:  Relationship First and Last Name SSN Date of Birth Proves Carrier No Vision No Carrier SSN Date of Birth Proves Carrier No No Carrier Son Daughter Step-child Step-child Son Daughter Step-child Step-chi						
O Modern Medical Plan O Bronze Medical Plan O Vision Plan (through Vision Service Plan) O Dental Plan (through Ameritas)  DEPENDENT ENROLLMENT (Complete for each eligible dependent)  SPOUSE'S EMPLOYER:  Relationship First and Last Name SSN Date of Birth group coverage?  Husband Son Son Step-child					CTION	BENEFIT ELI
O Bronze Medical Plan O Vision Plan (through Vision Service Plan) O Dental Plan (through Ameritas)  DEPENDENT ENROLLMENT (Complete for each eligible dependent)  SPOUSE'S EMPLOYER:  Relationship First and Last Name SSN Date of Birth group coverage?  Husband Nife Son No Daughter Step-child Step-child Carrier Step-child Carrier Son No Daughter Step-child Step-child Carrier Son No Daughter Step-child Step-child Carrier Son No Daughter Step-child Step-child Carrier Step-child Step-child Carrier Son No Daughter Step-child Step-child Carrier Step-child Step-child Carrier Step-child Step-child Carrier Step-child Step-child Carrier Step-child Step-child Step-child Carrier Step-child Step-child Step-child Carrier Step-child St			r:			
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DEPENDENT ENROLLMENT (Complete for each eligible dependent)    SPOUSE'S EMPLOYER:			hildren			
Relationship First and Last Name SSN Date of Birth group coverage?  Husband Son Step-child Step-child Son Son Step-child Son Step-child Step-child Son Step-child Step-child Son Step-child Step-child Son Step-child Step-ch					n (through Ameritas)	O Dental Pl
Relationship First and Last Name SSN Date of Birth group coverage?    Husband   No   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Son   Yes   Carrier    Son   Yes   Carrier    Son   No   Yes   Carrier    Son   No   Yes   Carrier    Step-child   Yes   Carrier				lo donandant)	ENDOLI MENT (Complete for each aligi	DEPENDENT
Relationship   First and Last Name   SSN   Date of Birth   group coverage?     Husband   No   Yes   Carrier     Son   No   No     Daughter   Yes   Carrier     Son   No   No     Step-child   Yes   Carrier     Son   No   No     Daughter   No   No     Step-child   Yes   Carrier     Son   No   No     Daughter   No   Yes     Step-child   Yes   Carrier     Son   No   No     Daughter   No   Yes     Step-child   Yes   Carrier     Son   No   No     Daughter   Carrier     Step-child   Carrier				ne dependent)	ENROLLIVIENT (Complete for each engin	DELENDENT
Husband					OYER:	SPOUSE'S EMP
Husband		1				
Husband   Wife				SSN	First and Last Name	Relationship
Wife			Birtii			☐ Husband
Son						□ Wife
Daughter   Yes   Carrier     Son   No     Daughter   Yes     Step-child   Yes     Step-child   Yes     Step-child   Yes     Step-child   Yes     Carrier     Son   No     Daughter   Yes     Step-child   Carrier     Son   No     Daughter   Yes     Step-child   Carrier     Son   No     Daughter   Yes     Step-child   Yes     Carrier     Son   No     Step-child   Yes     Carrier     Son   No     Daughter   Yes     Step-child   Carrier     Son   No     Daughter   Yes     Carrier		1				
□ Step-child         Carrier           □ Son         □ Yes           □ Step-child         Carrier           □ Son         □ No           □ Daughter         □ Yes           □ Step-child         Carrier           □ Son         □ No           □ Daughter         □ Yes           □ Step-child         Carrier           □ Son         □ No           □ Daughter         □ No           □ Step-child         □ Yes           □ Step-child         □ Carrier    EMPLOYEE SIGNATURE AND CONSENT						
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□ Daughter         □ Yes           □ Step-child         □ No           □ Daughter         □ Yes           □ Step-child         □ Carrier           □ Daughter         □ Yes           □ Step-child         □ Carrier           □ Son         □ No           □ Daughter         □ No           □ Daughter         □ Yes           □ Step-child         □ Carrier    EMPLOYEE SIGNATURE AND CONSENT						-
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direct administrative, professional, medical, or legal services in connection with my claims or care to disclose any information n investigation, evaluation, or payment of a claim. I certify that all information contained herein is true and correct.	necessary I					
Employee Signature Date			Date			Employee Signatur