2019 Open Enrollment Form for Modern Care, Bronze PPO, Dental and Vision Plans Enrollment/Changes

EDCARE GROUP

GROUP HEALTH PLAN ENROLLMENT FORM

EMPLOYEE ENROLLMENT

o Male
o Female

_____ _____ ___ _____

Last Name **First Name** **MI** **Social Security Number**

_____ _____

Complete Address – (Street # & Name, City, State, Zip Code) **Date of Birth**

Date of Hire_____ **Effective Date (leave blank)** _____ **Phone Number** _____

FOR EMPLOYER USE ONLY: o **Kingsburg Elementary** o **Fowler Unified** o **State Center CC**

o **New Hire** o **Change only** **If a change, prior coverage was through** _____

Date of Employment _____ **Coverage Effective Date** 10/1/2019 - OE

BENEFIT ELECTION

☐ **I elect the following coverage:**
- ☐ **Modern Medical Plan**
- ☐ **Bronze Medical Plan**
- ☐ **Vision Plan (through Vision Service Plan)**
- ☐ **Dental Plan (through Ameritas)**

☐ **I decline coverage for:**
- ☐ **Spouse**
- ☐ **Children**
- ☐ **Spouse and Children**

Reason: _____

DEPENDENT ENROLLMENT (Complete for each eligible dependent)

SPOUSE'S EMPLOYER: _____

Relationship	First and Last Name	SSN	Date of Birth	Does dependent have other group coverage?
☐ Husband ☐ Wife				☐ No ☐ Yes Carrier
☐ Son ☐ Daughter ☐ Step-child				☐ No ☐ Yes Carrier
☐ Son ☐ Daughter ☐ Step-child				☐ No ☐ Yes Carrier
☐ Son ☐ Daughter ☐ Step-child				☐ No ☐ Yes Carrier
☐ Son ☐ Daughter ☐ Step-child				☐ No ☐ Yes Carrier
☐ Son ☐ Daughter ☐ Step-child				☐ No ☐ Yes Carrier

EMPLOYEE SIGNATURE AND CONSENT

I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative, professional, medical, or legal services in connection with my claims or care to disclose any information necessary for investigation, evaluation, or payment of a claim. I certify that all information contained herein is true and correct.

_____ _____

Employee Signature **Date**