Use this form to enroll in either the Modern Care or Bronze PPO plan and/or enroll in Dental and Vision.

EDCARE GROUP

GROUP HEALTH PLAN ENROLLMENT FORM

| | | | | | o Male |
|---|--|--|------------------------|--|---------|
| Last Name | First Name | MI | Social Security Number | | o Femal |
| Complete Address – (St | reet # & Name, City, State, Zip Code) | | | Date of Birth | |
| Date of Hire | Effective Date (leave | e blank) | Ph | one Number | |
| FOR EMPLOYER USI | EMPLOYER USE ONLY: O Kingsburg Elementary O Fowler Unified | | O State Center CC | | |
| O New Hire Date of Employment | O Change only If a change | , prior coverage was throu Coverage Effective D | | | |
| BENEFIT ELECT | TION | | | | |
| O Dental Plan (t | ical Plan | | Children | | |
| | /ER: | | | | |
| Relationship | First and Last Name | SSN | Date of Birth | Does dependent have othe group coverage? | r |
| ☐ 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 | | | | □ No □ Yes | |
| □ Step-child | | | 1 | Carrier | |
| authorize all health ca lirect administrative, p | NATURE AND CONSENT re providers, claim processing agents, incorposessional, medical, or legal services in a, or payment of a claim. I certify that all | connection with my cl | aims or care | to disclose any information | |
| | | | | | |