CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Dr West, Albany, NY 12205

GROUP NAME _____

SECTION A

Last Name | First | M.I.

Address | County

City | State | Zip Code

Your Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

Phone No.: (____)_____ (____)_____

Employment Status: ☐ FT ☐ PT Hrs/Weekly_____ ☐ Active ☐ Retired ☐ COBRA

Hire Date ____/____/____ Status Chg Date ____/____/____

EMPLOYER USE ONLY

Effective Date ____/____/____

Retire Date ____/____/____

Grp No._____

Loc. Code_____

SECTION B

☐ Open Enrollment (complete Section D)

☐ New Enrollment/Reinstatement (complete Section D)

☐ Change Coverage to (check new coverage)

☐ Cancel Coverage (check what applies)

☐ Add/Delete Dependent (complete section D)

☐ Information Change (complete Section A)

☐ Waive Coverage (must provide proof of Insurance)

☐ NYS Dependent Coverage up to Age 29

	Carrier	Tier
Indem/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
PPO/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
POS/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
CDPHP EPO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
MVP HMO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Rx		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Dental		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Other		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr

Reason/Comments:

SECTION C

Other Coverage?

Is there coverage under any other group health plan available to you or any of your covered dependents?

☐ **Yes** ☐ **No**

If Yes; Policyholder Name | Relationship ☐ Self ☐ Spouse ☐ Child

Social Security Number | Birth Date

____/____/____ ____/____/____

Insurance Co. Name | Policy #

Plan Type ☐ Self only ☐ Self/Spouse ☐ Self/Child(ren) ☐ Fam

Coverage Type ☐ Health ☐ Drug ☐ Dental ☐ Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below)

SECTION D

ADD	DELETE	Relationship	Last First M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date (Copy of Medicare card required)	MVP HMO & BS POS ONLY Primary Care Physician (PCP)
☐	☐	**Self** ☐ M ☐ F		____/____/____	n/a	____/____/____	____/____/____ ____/____/____	
☐	☐	**Spouse/DP** ☐ M ☐ F		____/____/____	n/a	____/____/____	____/____/____ ____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____ ____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____ ____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____ ____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____ ____/____/____	

SECTION E

Do your dependents reside in your home? ☐ Yes ☐ No

If No, give address:_____

Do you have a disabled dependent beyond age 19? ☐ Yes ☐ No

List name(s):_____

Full-time college students age 19 and over (Dental Only):

List Names: School Name and Address:

_____ _____

_____ _____

_____ _____

Dependent Verification*

School District Representative (SDR) _____ (please initial)

Date: _____

* The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).

Applicant's Signature: _____

Date: _____

Employer's Signature: _____

Date: _____

White Copy – AMSURE Yellow Copy – EMPLOYER Pink Copy – EMPLOYEE