

# CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

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GROUP NAME \_\_\_\_\_

<b>SECTION A</b>	Last Name	First	M.I.	Your Social Security No. _____ - _____ - _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed  Date of Marriage ____ / ____ / ____    Date of Divorce ____ / ____ / ____ Phone No.: (____) _____ (____) _____ Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT Hrs/Weekly _____ <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA  Hire Date ____ / ____ / ____    Status Chg Date ____ / ____ / ____	<b>EMPLOYER USE ONLY</b>		
	Address					County	Effective Date ____ / ____ / ____ Retire Date ____ / ____ / ____
	City		State			Zip Code	Grp No. _____ Loc. Code _____

<b>SECTION B</b>	<input type="checkbox"/> Open Enrollment (complete Section D) <input type="checkbox"/> New Enrollment/Reinstatement (complete Section D) <input type="checkbox"/> Change Coverage to (check new coverage) <input type="checkbox"/> Cancel Coverage (check what applies) <input type="checkbox"/> Add/Delete Dependent (complete section D) <input type="checkbox"/> Information Change (complete Section A) <input type="checkbox"/> Waive Coverage (must provide proof of Insurance) <input type="checkbox"/> NYS Dependent Coverage up to Age 29	<b>Carrier</b>	<b>Tier</b>	<b>SECTION C</b>	<b>Other Coverage?</b>	
					Is there coverage under any other group health plan available to you or any of your covered dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	
					If Yes: Policyholder Name _____ Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
					Social Security Number _____ Birth Date ____ / ____ / ____    ____ / ____ / ____	
					Insurance Co. Name _____ Policy # _____	
					<b>Plan Type</b> <input type="checkbox"/> Self only <input type="checkbox"/> Self/Spouse <input type="checkbox"/> Self/Child(ren) <input type="checkbox"/> Fam	
					<b>Coverage Type</b> <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
	<b>Reason/Comments:</b> _____					

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

<b>SECTION D</b>	ADD	DELETE	Relationship	Last	First	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date	<b>MVP HMO &amp; BS POS ONLY</b>
											Primary Care Physician (PCP)
	<input type="checkbox"/>	<input type="checkbox"/>	<b>Self</b> <input type="checkbox"/> M <input type="checkbox"/> F				____ / ____ / ____	n/a	____ / ____ / ____	____ / ____ / ____	
	<input type="checkbox"/>	<input type="checkbox"/>	<b>Spouse/DP</b> <input type="checkbox"/> M <input type="checkbox"/> F				____ / ____ / ____	n/a	____ / ____ / ____	____ / ____ / ____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	____ / ____ / ____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	____ / ____ / ____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	____ / ____ / ____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	____ / ____ / ____	

<b>SECTION E</b> Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give address: _____  Do you have a disabled dependent beyond age 19? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	

## **GENERAL AUTHORIZATION**

My signature on this form authorizes my employer to make any required payroll deductions.

All information furnished hereon is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. I hereby authorize my employer to make any required payroll deductions.

I understand that the benefits for which I will be eligible are in accordance with those described in the applicable carrier contract/certificate and any attached riders.

I understand that unresolved grievances are subject to the procedure specified in the respective carrier contract/certificate and in coordination with that which is deemed applicable by DFS law.

I the undersigned hereby authorize the use and disclosure of personal health information as necessary, and as permitted by law. I understand that Amsure, a division of ATCFISI is required by law to maintain the privacy of personal health information as required by law regarding the privacy practices with respect to personal health information.