Pennsylvania

An Independent Licensee of the
Blue Cross and Blue Shield Association

CST

Department 778976
Harrisburg, PA 17177-8976

FOR OFFICE USE ONLY

- ❑ New Hire ____________Effective Date
- ❑ Open Enrollment ____________Employer Code
- ❑ Address Change____________
- ❑ Name Change____________
- ❑ Add Dependent____________
- ❑ Deceased____________
- ❑ Change of Benefits____________
- ❑ Other____________

Check One

___1 Active
___2 Retiree
___3 COBRA

CENTRAL SUSQUEHANNA REGION SCHOOL EMPLOYEES' HEALTH AND WELFARE TRUST

SCHOOL EMPLOYER: Shamokin Area School District

ENROLLMENT/CHANGE FORM

Please type or print - Incomplete or illegible information will delay your enrollment.

I. GENERAL EMPLOYEE INFORMATION

Employee's Last Name	First Name		MI	Social Security #	Date of Birth
Present Address	Home Phone #	Sex	Marital Status	Date of Hire	Coverage Effective Date
City	State		Zip Code		

II. ENROLLMENT INFORMATION

Check Coverages:

☐ Traditional Medical/RX

- ☐ Single
- ☐ Two-Person Family
- ☐ Family
- ☐ Single, 65-Special
- ☐ Two-Person, both 65
- ☐ Two-Person, one 65
- ☐ Family, 65 - Special

☐ PPO Medical/RX

- ☐ Single
- ☐ Two-Person Family
- ☐ Family
- ☐ Single, 65-Special
- ☐ Two-Person, both 65
- ☐ Two-Person, one 65
- ☐ Family, 65 - Special

III. DEPENDENT INFORMATION (COMPLETE ONLY IF DEPENDENT COVERAGE IS ELECTED.)

Dependent Full Name	Relationship	Sex	Social Security Number	Date of Birth	Coverage Effective Date	Termination Effective Date

A. If Dependent is a Full-time student and over age 19, please complete the following:

Dependent Full Name	Name of accredited school or university	Expected Graduation Date

B. If a Dependent does not live with you, please explain. ____________________

C. If a Dependent last name differs from yours, please explain. ____________________

IV. MEDICARE COVERAGE INFORMATION
(IF YOU OR YOUR DEPENDENT ARE CURRENTLY COVERED BY MEDICARE, COMPLETE THE FOLLOWING)

Medicare Recipient	Health Insurance Claim #	EFFECTIVE DATE(S PART A (Hospital) Mo Day Year	PART B (Medical) Mo Day Year	Reason for Medicare Entitlement (Check One):
		/ /	/ /	❑ Age ❑ Disabled ❑ End Stage Renal Disease ❑ End Stage Renal Disease and Disabled
		/ /	/ /	❑ Age ❑ Disabled ❑ End Stage Renal Disease ❑ End Stage Renal Disease and Disabled

V. OTHER COVERAGE INFORMATION

Are any of your children required to be covered under any other Medical Plan by provisions of a Court or Domestic Relations order? ❑ YES ❑ NO

If 'YES', please explain: ______________________________

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Are you, your spouse, or any of your children covered under any OTHER Medical Plan? ❑ YES ❑ NO

If 'YES', please complete the following:

Participant	Name of Plan	Coverage Provided	Policy #

VI. EMPLOYEE AUTHORIZATION

1. I hereby apply for benefits provided by my employer's group plan. I reserve the right to revoke this authorization at any time upon written notice.
2. I hereby certify that the dependents listed are my dependents as defined by my employer. I agree to notify my employer of any change in status of any dependent or of any additional dependents I may acquire.
3. In the event I or my dependents suffer illness or injury because of an act or omission of a third party, I agree to so advise my employer or the plan administrator.

Employee Signature ______________________________ Date ______________

Employer Authorization ______________________________ Date ______________

TO DECLINE COVERAGE

I understand that I am eligible for benefits under the Group Health Plan for the Employee named above I certify that benefits under such Plan have been explained to me in detail. After careful consideration, I decline coverage under such Plan for myself because I am covered under another Health Coverage Plan and waive all claims to benefits under such Plan.

Employee Signature ______________________________ Date ______________

TO DECLINE DEPENDENT COVERAGE

I understand that my dependents are eligible for benefits under the Group Health Plan. I certify that benefits under such Plan have been explained in detail. After careful consideration, I decline coverage under such Plan for my dependents.

Employee Signature ______________________________ Date ______________

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 subjects such person to criminal and civil penalties.

VII. EMPLOYER COMMENTS