SOUTHEASTERN SCHOOLS	ENROLLMENT FORM for OCTOBER 1, 2016								
					MEDICAL	DENTAL	VISION	WAIVE ALL	NO CHANGE
A) EMPLOYEE INFORMATION:					Circle Selection			Check Selection	
NAME:					YES/NO	YES/NO	YES/NO		
ADDRESS:									
SOCIAL SECURITY NUMBER (REQUIRED):									
DATE OF BIRTH:			Gender: M / F						
MARITAL STATUS (CIRCLE ONE):	SINGLE	MARRIED	DIVORCED	WIDOWED					
PLAN OPTION (CIRCLE ONE):	**PPO CORE**		**HDHP**						
B) FAMILY INFORMATION:									
NAME OF SPOUSE:					YES/NO	YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):					Address if different from Employee:				
DATE OF BIRTH:			Gender: M / F						
RELATIONSHIP TO EMPLOYEE:									
NAME OF DEPENDENT (1):					YES/NO	YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):					Address if different from Employee:				
DATE OF BIRTH:			Gender: M / F						
RELATIONSHIP TO EMPLOYEE:									
NAME OF DEPENDENT (2):					YES/NO	YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):					Address if different from Employee:				
DATE OF BIRTH:			Gender: M / F						
RELATIONSHIP TO EMPLOYEE:									
NAME OF DEPENDENT (3):					YES/NO	YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):					Address if different from Employee:				
DATE OF BIRTH:			Gender: M / F						
RELATIONSHIP TO EMPLOYEE:									
IF MORE DEPENDENTS, PLEASE WRITE INFORMATION ON ANOTHER SHEET OF PAPER AND ATTACH									
The DEPENDENT AFFIDAVIT must be completed for all enrolling dependents									
C) THIS SECTION MUST BE COMPLETED IF YOU HAVE OTHER MEDICAL INSURANCE									
DO YOU OR ANY DEPENDENTS HAVE OTHER HEALTH COVERAGE?				**YES**	**NO**				
IF YES, PROVIDE INFORMATION BELOW									

NAME OF POLICY HOLDER	NAME OF OTHER INSURANCE CO.	POLICY NUMBER	POLICY TYPE (single, etc.)
ARE YOU COVERED BY MEDICARE?		**YES** **NO**	***INELIGIBLE**
ARE YOUR SPOUSE AND/OR DEPENDENTS COVERED BY MEDICARE?		**YES** **NO**	***INELIGIBLE**
IF ENROLLED IN MEDICARE, PLEASE ATTACH A COPY OF MEDICARE ID CARD(S)			
*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are			
not eligible for Medicare.			
SIGNATURE: I confirm that the information I have provided on this form is complete and accurate.			
(Employee Signature)	(Date)		