NEW RICHMOND EXEMPTED VILLAGE SCHOOLS

Medical & Dental Enrollment Form

Effective Date: ______________________________

Medical Plan: Family Single

Dental Plan: Family Single

Reason for Change ___________________________

A) EMPLOYEE INFORMATION:

			MEDICAL	DENTAL	WAIVE ALL
NAME:			YES/NO	YES/NO	
ADDRESS:					
SOCIAL SECURITY NUMBER (REQUIRED):					
DATE OF BIRTH:		Gender: M / F			
MARITAL STATUS (CIRCLE ONE):	SINGLE MARRIED	DIVORCED WIDOWED			

B) FAMILY INFORMATION:

NAME OF SPOUSE:			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	
SOCIAL SECURITY NUMBER (REQUIRED):			Address if different from Employee:		
DATE OF BIRTH:		Gender: M / F			
RELATIONSHIP TO EMPLOYEE:		Married: Y / N			

NAME OF DEPENDENT (2):			YES/NO	YES/NO	
SOCIAL SECURITY NUMBER (REQUIRED):			Address if different from Employee:		
DATE OF BIRTH:		Gender: M / F			
RELATIONSHIP TO EMPLOYEE:		Married: Y / N			

NAME OF DEPENDENT (3):			YES/NO	YES/NO	
SOCIAL SECURITY NUMBER (REQUIRED):			Address if different from Employee:		
DATE OF BIRTH:		Gender: M / F			
RELATIONSHIP TO EMPLOYEE:		Married: Y / N			

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)

B) FAMILY INFORMATION: (continued)

		MEDICAL	DENTAL	WAIVE ALL	
NAME OF DEPENDENT (4):		YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):		Address if different from Employee:			
DATE OF BIRTH:	Gender: M / F				
RELATIONSHIP TO EMPLOYEE:	Married: Y / N				
NAME OF DEPENDENT (5):		YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):		Address if different from Employee:			
DATE OF BIRTH:	Gender: M / F				
RELATIONSHIP TO EMPLOYEE:	Married: Y / N				
NAME OF DEPENDENT (6):		YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):		Address if different from Employee:			
DATE OF BIRTH:	Gender: M / F				
RELATIONSHIP TO EMPLOYEE:	Married: Y / N				
NAME OF DEPENDENT (7):		YES/NO	YES/NO		
SOCIAL SECURITY NUMBER (REQUIRED):		Address if different from Employee:			
DATE OF BIRTH:	Gender: M / F				
RELATIONSHIP TO EMPLOYEE:	Married: Y / N				