

# Cayuga-Onondaga Area School Employees' Healthcare Plan Enrollment Form\*

**Traditional Plan**

**Modified Traditional Plan**

<input type="checkbox"/> Cato-Meridian <input type="checkbox"/> Cay-Onon BOCES \$10/\$15 (CAY) <input type="checkbox"/> Cay-Onon BOCES 100% (CAU) <input type="checkbox"/> Jordan-Elbridge <input type="checkbox"/> \$3/3 <input type="checkbox"/> Moravia - RX <input type="checkbox"/> Port Byron <input type="checkbox"/> 100% (PTB) <input type="checkbox"/> (POT) <input type="checkbox"/> Port Byron- <input type="checkbox"/> \$10 (PBA) <input type="checkbox"/> \$8 (POR) <input type="checkbox"/> Port Byron <input type="checkbox"/> \$3 (PPR) <input type="checkbox"/> \$10/\$12 (PRB) <input type="checkbox"/> Skaneateles <input type="checkbox"/> Southern Cayuga-Rx <input type="checkbox"/> (SOY) 100% <input type="checkbox"/> Southern Cayuga-Rx <input type="checkbox"/> (SOU) \$10/\$15 <input type="checkbox"/> Union Springs <input type="checkbox"/> Weedsport	Last Name _____  First Name _____  Address _____ County _____  City/ State/ Zip _____ Home Phone _____ Business Phone _____  SS#: _____ Sex: _____ Male ___ Female  Date Of Birth: _____	<input type="checkbox"/> Cato-Meridian <input type="checkbox"/> Cay-Onon BOCES <input type="checkbox"/> Jordan-Elbridge <input type="checkbox"/> Moravia <input type="checkbox"/> Port Byron <input type="checkbox"/> Skaneateles <input type="checkbox"/> Southern Cayuga <input type="checkbox"/> Union Springs <input type="checkbox"/> Weedsport
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<input type="checkbox"/> Active Single <input type="checkbox"/> Retired Single Under 65 <input type="checkbox"/> Active Family <input type="checkbox"/> Retired Family Under 65 <input type="checkbox"/> Retired Single Over 65 <input type="checkbox"/> Retired Family Both Over 65 <input type="checkbox"/> Retired One Over 65, One Under 65 <input type="checkbox"/> Cobra	<b>COVERAGE: MEDICAL</b>  <input type="checkbox"/> Employee Only  <input type="checkbox"/> Employee & Family  <input type="checkbox"/> No Coverage	<b>MARITAL STATUS:</b>  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
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**Spouse**  
 Name (First, Last) \_\_\_\_\_ Sex \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouses address (if different) \_\_\_\_\_

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**Children**

Name (First, Last)	Relationship	Sex	Date Of Birth	Social Security #	School/College, City/State

**Spouse Information (Must be completed)** Medicare Eligible:  Yes  No  
 Is spouse employed:  Yes  No Enrolled in Group Health Plan:  Yes  No  Single  Family

Name, Address, and Phone # of Spouse's Employer: \_\_\_\_\_

Name, Address, and Phone # of Other Health Insurance Coverage: \_\_\_\_\_

I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, SURGEON OR PHARMACY TO RELEASE INFORMATION REQUESTED BY CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN OR ITS REPRESENTATIVES TO PROCESS CLAIMS INVOLVING ME OR MY FAMILY. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO ANY DOCTOR, PHYSICIAN OR OTHER PROVIDER FOR SERVICES WHICH HE/SHE MAY RENDER TO ME OR MY FAMILY. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I DESIRE TO PARTICIPATE IN THE GROUP MEDIAL PROGRAM AND AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION FROM MY WAGE OR SALARY TO PAY MY PART OF THE COST.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

<b>OFFICE USE ONLY</b>	<b>EMPLOYER'S STATEMENT</b>
	EFFECTIVE DATE _____ HIRE DATE _____ CERTIFIED BY _____