SISCO
experience the benefits

Health & Dental Enrollment / Change Form

SECTION I – EMPLOYEE INFOMRATION AND COVERAGE ELECTION

Employer Name Jackson County	**Group # 2219**		**Division**	**Plan**
Name (First, MI, Last		Social Security #		Hire Date
Street Address		Telephone		Effective Date
City State Zip		Date of Birth		Email Address

☐Male ☐Female Marital Status ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Widow/Widower

Medical	Dental	**Reason for Completing this Form**	Date of Event Change
☐ Single ☐ EE + Children ☐ EE + Spouse ☐ Family ☐ Decline	☐ Single ☐ EE + Children ☐ EE + Spouse ☐ Family ☐ Decline	☐New Hire ☐Part/Full-time Change ☐Late Enrollment ☐Special Enrollment/Loss of Coverage ☐Marriage / Birth / Adoption Date coverage lost _____ ☐Terminate Coverage for one/all dependents ☐Voluntary or ☐List dependents who are no longer covered ☐Lost other coverage _____	____/____/____

SECTION II – ELIGIBLE DEPENDENTS INFORMATION Note. This application does not guarantee coverage.

Name (First, MI, Last)	**Relationship**	**Social Security # - (SSN) Federal law MMSEA requires collection of SSN for all dependents**	**Date of Birth**	**Gender**
Spouse:	☐Spouse (lawful) ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female
Dependent:	☐Natural/Adopted ☐Step Child ☐Foster Child ☐Other			☐Male ☐Female

SECTION III – OTHER COVERAGE Note: This section must be completed for SISCO to process your dependent claims.

PART A: Spouse (if applicable) **Date of Marriage:**

Name & City of Employer _____
Does your spouse have other coverage with this employer?
☐Yes ☐No
If no, is he/she eligible for other coverage with this employer?
☐Yes ☐No
If your spouse does have other coverage through this employer:
1. Indicate the type of coverage
   ☐Medical ☐Dental ☐Prescription Drug ☐Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan_____
   _____

PART B: Ex-spouse (if applicable) **Divorce Date:**

(This information is for Coordination of Benefits for any dependent children)
Ex-Spouse Name(s)_____
Address(es) _____
Social Security # (if available) _____
Name and City of Employer(s)
_____
If your ex-spouse has coverage through this employer:
1. Indicate the type of coverage
   ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan_____
   _____

Does your spouse or any other dependents have Medicare? ☐ **Yes If yes, who?** _____ ☐ **No**
Are your spouse or any dependents disabled? ☐ **Yes If yes, who?** _____ ☐ **No**

SECTION IV – SIGNATURE TO ELECT OR DECLINE COVERAGE

Elect: *The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings (pre-tax if applicable). I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments, this auth will be used for verification of benefit eligibility and claim processing. This consent is subject to revocation at any time through a written submission to SISCO.*

Decline: *I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.*

☐ I do have other coverage
☐ I do not currently have other coverage

Signature	**Date**	**Signature**	**Date**