STAYWELL
MENDOCINO COUNTY SCHOOL DISTRICTS HEALTH PLAN

Enrollment Form

Indicate Health Plan below:

- ❑ Medical – Active Plan
- ❑ Medical – Retiree Health - Active Plan
- ❑ Medical – Retiree Health - Retiree Plan

Indicate reason for application:

- ❑ New enrollment effective_____
- ❑ Open enrollment
- ❑ Add Dependent
  Date of Marriage: _____
  Date of Birth:_____
  Date of Adoption:_____
- ❑ Plan Change
- ❑ Terminate Coverage for checked plans on left
- ❑ Change Address/Name
- ❑ Delete Dependent (list names below)

Location/District: _____

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	HOME PHONE ( )

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

MARRIED ❑ YES ❑ NO	SEX ❑ M ❑ F	BIRTH DATE	JOB TITLE	DATE EMPLOYED

EMPLOYER NAME	NO OF HOURS WORKED/WEEK

Are you actively at work? ❑ YES ❑ NO

Are you covering your dependents? ❑ YES ❑ NO

Relation To Employee	Last Name	First Name	Date of Birth	SSN #	SEX (M/F)
Spouse					
Dependent Child					
Dependent Child					
Dependent Child					

Do you or your dependents have other medical coverage? ❑ No ❑ Yes (❑ Self ❑ Spouse ❑ Children)
If yes, what was the effective date of the Policy? _____

NAME OF INSURED	SOCIAL SECURITY NUMBER	NAME OF OTHER INSURANCE COMPANY	GROUP NO.

EMPLOYER OF INSURED	EMPLOYER ADDRESS	CITY	STATE	ZIP

To the best of my knowledge, I believe the above information is true and correct. I understand that false or inaccurate information may result in the termination of coverage or the non-payment of benefits.

Employee Signature _____ Date Signed _____

Waiver of Insurance Coverage

Rejection of Health Coverage. After careful consideration, I do not wish to participate in any of the available plans. I also realize I will NOT be able to re-enroll until next open enrollment period and then I may be required to provide Medical Proof of Insurability.

Employee Signature _____ Date Signed _____