



Cortland County GROUP BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

- MANAGEMENT
- NURSES
- GENERAL CSEA
- ROAD
- CIVILIAN
- CORRECTIONS

LAST NAME: _____
 FIRST NAME: _____
 SEX: MALE FEMALE

- MARITAL STATUS:
- SINGLE
 - MARRIED
 - DIVORCED
 - LEGALLY SEPARATED

SS #: _____
 DATE OF BIRTH _____
 DATE OF HIRE _____
 EFFECTIVE DATE _____

- ACTIVE (PART-TIME)
- ACTIVE (FULL-TIME)
- COBRA
- RETIRED WITH OUT MEDICARE
- RETIRED WITH MEDICARE
 MEDICARE CLAIM NO. _____
 PART A EFF. DATE: _____
 PART B EFF. DATE: _____

ADDRESS: _____
 STREET _____
 CITY, STATE, ZIP _____
 COUNTY _____
 HOME PHONE _____
 BUSINESS PHONE _____

	INDIVIDUAL	FAMILY
MEDICAL (INCLUDES PRESCRIPTION)	_____	_____
DENTAL	_____	_____
VISION	_____	_____

Spouse Name (First, Last) Sex Date of Birth Social Security #

Children Name (First, Last) Relationship Sex Date of Birth Social Security # College Name Disabled Y/N?

Spouse Information (Only complete if enrolling spouse) Medicare Eligible? Yes No Medicare Claim No. _____
 Is spouse employed? Yes No Enrolled in Group Health Plan? Yes No Part A Eff. Date: _____
 Type of Coverage: Medical Dental Prescription Vision Part B Eff. Date: _____
 Single Family

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

Name, Address, and Policy Number of Other Health Insurance Coverage: _____

I 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 MEDICAL PROGRAM.

DATE

SIGNATURE OF EMPLOYEE