



1099 Wall Street West, Lyndhurst, NJ 07071
 1 (888) 4-INDECS (446-3327)
 Fax (201) 460-3204

Form #OUSD-4510E-3/09

ENROLLMENT



ORANGE - ULSTER
 SCHOOL DISTRICTS
 HEALTH PLAN

For Enrollment Only

Check Type:

Initial Reinstatement

ENROLLEE'S SCHOOL DISTRICT:

ENROLLEE/MEMBER INFORMATION

Last Name First Name Initial SSN DOB ^M^M^D^D^Y^Y^Y^Y Sex M F

Street Address City State Zip Code Marital Status: Single Married
 Divorced Legally Separated

COVERAGE: Type: Individual (skip to Other Coverage section) Family (fully complete form)
 Active Retired Surviving Spouse

Date of Marriage/Divorce or Legal Separation

^M^M^D^D^Y^Y^Y^Y

When applying for other than individual coverage, list all eligible dependents. Indicate relationships by selecting choices from drop down box. (If other, detail in remarks and submit legal documentation.) Complete additional family information form if space is insufficient.

Spouse	First Name	MI	Last Name (If different)	Date of Birth	Spouse's SSN is required.
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	SSN <input style="width: 100%;" type="text"/>
Dep/Relationship	First Name	MI	Last Name (If different)	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	SSN <input style="width: 100%;" type="text"/>
Dep/Relationship	First Name	MI	Last Name (If different)	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	SSN <input style="width: 100%;" type="text"/>
Dep/Relationship	First Name	MI	Last Name (If different)	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^M <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^D <input style="width: 30px;" type="text"/> ^Y <input style="width: 30px;" type="text"/> ^Y	SSN <input style="width: 100%;" type="text"/>

More dependents, complete Enrollment Continuation on next page Other, complete remarks Remarks:

CERTIFICATE OF COVERAGE/PLAN DESCRIPTION INFORMATION

Federal regulation require that your covered dependents be notified of certain Plan provisions. You must indicate that you will send a copy of your Certificate of Coverage to all other Plan beneficiaries, or indicate where Certificate of Coverage information is to be sent.

I will convey coverage information, or send additional info to: Name Email

Street Address City State Zip Code

OTHER COVERAGE INFORMATION

Are there any other hospital, medical or group health benefits provided to you, your spouse or other dependents which furnish services or similar coverage to those for which you are enrolling? Yes No If yes, complete the following:

Person with other coverage:	Single <input type="checkbox"/>	Family <input type="checkbox"/>	ID or Group No.	Plan Name-Address	Effective Date
<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

AUTHORIZATION/CERTIFICATION

I understand that the Plans and coverages listed above shall be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent disclosures are punishable by law. **(PRINT, SIGN and DATE ORIGINAL.)**

Print Name Signature Current Date

LOCAL ADMINISTRATORS - (MUST BE COMPLETED)

Enrollee's Hire Date Coverage Effective Date

I certify that I have the original of this document, signed by the Enrollee, which will be maintained by this District.

Print Name Signature Current Date



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ENROLLMENT Continuation



ORANGE - ULSTER
 SCHOOL DISTRICTS
 HEALTH PLAN

For Enrollment Only

Check Type:

Initial Reinstatement

ENROLLEE'S SCHOOL DISTRICT:

Dep/Relationship	First Name	MI	Last Name	Date of Birth						SSN	Full-Time Student	Handicapped
				M	M	D	D	Y	Y		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 20px; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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