DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

SECTION 1

Your Last Name | First | M.I | Your Social Security No.

Address

City | State | Zip Code

Employment Status: ☐Full-time ☐Part-time ☐Active ☐ Retired ☐COBRA

Date Of Employment / / Date Of Retirement / /

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Domestic Partner

Date of Marriage / /

Date Of Divorce / /

Phone No. ( ) -

( ) -

Employer Use Only

Group Name

Group No. | Employee Code

Effective Date Requested

R&K Use Only

Employee No. | Billing Class | Group Code

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)

☐ Change Coverage to: (check new coverage)

☐ Cancel Coverage: (check those that apply)

☐ Add or Delete Dependent: (complete section 4)

☐ Change Enrollee's information: (complete Section 1 with new information)

Reason :

Group#	Plan	IND	2PER	FAM	MCARE
	Healthy Adv PPO	☐	☐	☐	☐
	EPO - 20	☐	☐	☐	☐
	Alt PPO	☐	☐	☐	☐
	HMO	☐	☐	☐	☐
	Dental	☐	☐	☐	☐
	Vision	☐	☐	☐	☐

SECTION 3

Other Coverage?
Is there Coverage Under any other group health plan available to you or any member of your family
☐ **NO** ☐ **Yes**

If Yes; Policyholder Name | Relationship ☐ Self ☐Spouse ☐ Child

Social Security Number - - | Birthdate / /

Insurance Company Name | Policy Number

Address

Plan Type: ☐Self only ☐Self and Family

Coverage Type: ☐Health ☐Drug ☐Dental ☐Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

COPY OF MEDICARE CARD REQUIRED

ADD	DEL	RELATION-SHIP	NAME LAST FIRST M.I.	Birthdate (mo/day/yr)	Social Security #	Medicare A&B	Effective Date
☐	☐	☐M ☐F	SELF			A	B
☐	☐	☐ Husband ☐ Wife ☐ Domestic Partner				A	B
☐	☐	☐ Son ☐Daughter				A	B
☐	☐	☐ Son ☐Daughter				A	B
☐	☐	☐ Son ☐Daughter				A	B
☐	☐	☐ Son ☐Daughter				A	B

SECT. 5

Do you have a disabled dependent beyond age 26?

☐No ☐Yes List Name(s):

Full-time college student information if applicable to coverage

List name(s): School Name and Address Expected Graduation:

Applicants Signature: Date: | Adult Dependent Signature: Date: | Employer's Signature: