SIHO INSURANCE SERVICES
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GREENE COUNTY

HEALTH CARE ENROLLMENT APPLICATION

EMPLOYEES MUST COMPLETE SECTIONS A through D. PLEASE PRINT ALL INFORMATION.

FOR EMPLOYER HR USE ONLY ID#:_____
Subgroup / Location:_____ Plan Choice: _____
Approval: _____ Effective Date: _____

Sect. A — About You (REQUIRED)

Last Name First M.I. Social Security Number

Street Address (Home) City State Zip Code

Birth Date (Month/Day/Year) Sex: ☐ M ☐ F Telephone: Day Evening

Marital Status *(Single/Married/Divorced/Separated)* Hire Date

Employee Email Address: _____

EOB preference (Please choose one): ☐ Email Notification or ☐ Print Apply to all under 18 dependents ☐ Yes ☐ No

Sect. B — Coverage Options

Medical & RX: ☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Vision: ☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Sect. C — About Your Dependents (if applicable)

Please complete the section below only for each person to be covered. Place a ✓ for coverage selection.

Name Last First MI (Specify Last Name if different)	Sex M/F	Birthday Mo./Day/Year	Social Security Number	Relation to Employee: Natural Child	Relation to Employee: Step Child	Relation to Employee: Other	Disabled Dep.
02 Spouse							
03 Child							
04 Child							
05 Child							
06 Child							

For additional children, please attach a separate page. Be sure to include the information requested above. For adult dependents age 18 and older please fill out the second page of this enrollment form.

Sec D

Is your spouse employed? ☐ Yes ☐ No Is medical, dental or vision coverage available? ☐ Yes ☐ No

Is any member of your family covered under your spouse's plan or any other health insurance plan? ☐ Yes ☐ No

*If you answered yes to the above question it is required that you fill out ***page 3*** of this form.

OVER ⟶

NOTE: Please attach a Certificate of Creditable Coverage for yourself and/or your dependents if you have been previously covered under another group health plan.

OVER ⟶

ADD DEPENDENTS AGE 18 AND OLDER TO PLAN

For more than two dependents 18 or older, please copy below sheet and attach with form.

Benefits to Add: ☐ Medical ☐ Vision

Reason to add : _____ **Examples:** Loss of other coverage, Marriage, Birth, Adoption, Custody or Legal Guardianship, etc...

Full Name	Sex M/F	Birth Date (MM/DD/YY)	Social Security Number	Relation to Employee	Date for insurance to be effective

Please provide physical residence address if other than your physical address:

_____

Street Address (Home) City State Zip Code

Is this dependent employed? ☐ **Yes** ☐ **No** If yes, is insurance coverage available through employer? ☐ **Yes** ☐ **No**

If yes, and coverage is available: Policy Holder relationship:_____ Date of Birth: _____

Insurance Co.: _____ Address:_____ Policy #: _____

What benefits do they have? ☐ Medical ☐ Dental ☐ Vision Effective date: _____

Is this dependent insured elsewhere other than through an employer sponsored plan? ☐ **Yes** ☐ **No**

If yes, and coverage is other than listed above: Policy Holder relationship:_____ Date of Birth: _____

Insurance Co.: _____ Address:_____ Policy #: _____

What benefits do they have? ☐ Medical ☐ Dental ☐ Vision Effective date: _____

Dependent Email Address: _____

EOB preference (Please choose one): ☐ Email Notification or ☐ Print

Benefits to Add: ☐ Medical ☐ Vision

Reason to add : _____ **Examples:** Loss of other coverage, Marriage, Birth, Adoption, Custody or Legal Guardianship, etc...

Full Name	Sex M/F	Birth Date (MM/DD/YY)	Social Security Number	Relation to Employee	Date for insurance to be effective

Please provide physical residence address if other than your physical address:

_____

Street Address (Home) City State Zip Code

Is this dependent employed? ☐ **Yes** ☐ **No** If yes, is insurance coverage available through employer? ☐ **Yes** ☐ **No**

If yes, and coverage is available: Policy Holder relationship:_____ Date of Birth: _____

Insurance Co.: _____ Address:_____ Policy #: _____

What benefits do they have? ☐ Medical ☐ Dental ☐ Vision Effective date: _____

Is this dependent insured elsewhere other than through an employer sponsored plan? ☐ **Yes** ☐ **No**

If yes, and coverage is other than listed above: Policy Holder relationship:_____ Date of Birth: _____

Insurance Co.: _____ Address:_____ Policy #: _____

What benefits do they have? ☐ Medical ☐ Dental ☐ Vision Effective date: _____

Dependent Email Address: _____

EOB preference (Please choose one): ☐ Email Notification or ☐ Print

COORDINATION OF BENEFITS QUESTIONS
OTHER COVERAGE INFORMATION

About Your Spouse *(if applicable)*

Please complete this section if other coverage is provided through your spouse.

Place of Employment: _____ Address: _____

Name of insurance Co: _____ Address: _____

Phone: _____ Policy ID Number: _____ Effective date: _____

Is the subscriber: ☐ Full Time ☐ Self Employed ☐ Retired, if so Date of Retirement: _____

Type of Coverage: ☐ Medical/RX ☐ Dental ☐ Vision Is this Plan: ☐ Active ☐ Retiree ☐ COBRA

Please list Covered Members: Spouse:_____ Date Of Birth: _____

Child:_____ Child:_____ Child:_____ Child:_____

Medicare Coverage *(if applicable)*

Please complete this section if other coverage is provided through Medicare.

Are you or your spouse eligible for Medicare: ☐ Yes ☐ No

Part A effective date:_____ Part B effective date:_____

Reason for Medicare Coverage:
☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease, Date Dialysis Began: _____

About Your Former Spouse *(if applicable)*

Please complete if other coverage is provided through a former spouse.

Place of Employment: _____ Address: _____

Name of insurance Co: _____ Address: _____

Phone: _____ Policy/Group Number: _____ Effective date: _____

Is the subscriber: ☐ Full Time ☐ Self Employed ☐ Retired, if so Date of Retirement: _____

Type of Coverage: ☐ Medical/RX ☐ Dental ☐ Vision Is this Plan: ☐ Active ☐ Retiree ☐ COBRA

Please list Covered Members Former Spouse:_____ Date Of Birth: _____

Child:_____ Child:_____ Child:_____ Child:_____

AUTHORIZATION/DECLINATION OF COVERAGE

Please select one of the following options and sign below.

Authorization ☐

I authorize hospitals, physicians or other providers of service to furnish SIHO (acting as the TPA for my employer), upon request, any and all reports and records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents under age 18 after this date, together with like reports and records or copies thereof of earlier services for purposes of processing this application and for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. In recognition of the legitimate interest of my employer in reviewing historical data setting forth the volume, nature and costs of healthcare services paid by my employer, I hereby authorize SIHO to provide my employer plan with information relating to medical services and treatment rendered to me and/or my dependents under age 18 listed on this application.

I, for myself and for those of my eligible dependents listed above, hereby agree to abide by the rules, regulations and terms of my employer's group health plan documents as such documents may be amended. I shall cooperate and assist SIHO in the exercise of the subrogation and coordination of benefits rights of my employer's plan. I certify that the information furnished is true and complete to the best of my knowledge.

Declination ☐

I am declining enrollment for myself and dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

_____ _____ _____
Employee Signature Print Name Date