KETTERING CITY SCHOOLS

INSURANCE APPLICATION

	CIRCLE ALL THAT APPLIES	POSITION	FULL TIME	PART TIME/HRS
NEW ENROLLMENT	YES			
CANCEL INSURANCE	YES	INSURANCE EFFECTIVE DATE		
ADD DEPENDENT	YES			
CANCEL DEPENDENT	YES	DATE EMPLOYED		
NAME CHANGE	YES			

		MEDICAL	DENTAL	WAIVE ALL
(A) EMPLOYEE INFORMATION Name		YES / NO	YES / NO	INELIGIBLE
Address				
Social Security number				
Date of Birth	Gender: M / F			
Marital Status (Circle one)	Single Married Divorced Widowed			
(B) FAMILY INFORMATION Spouse		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				
Name of Dependent		YES / NO	YES / NO	
Social Security number		address if different than employee		
Date of Birth	Gender: M / F			
Relationship to employee				

IF MORE DEPENDENTS, PLEASE WRITE INFORMATION ON ANOTHER SHEET OF PAPER AND ATTACH

(C) THIS SECTION MUST BE COMPLETED IF YOU HAVE OTHER MEDICAL INSURANCE

Do you or any dependents have other health coverage?		YES	NO
If yes, provide information			
Name of Policy Holder	Name of other Insurance Co	Policy #	Policy Type (single, etc)
Are you covered by Medicare?		YES	NO
Are your spouse and/or dependents covered by Medicare?		YES	NO
If enrolled in Medicare, please attach a copy of Medicare ID card(s)			

(D) LIFE INSURANCE BENEFICIARY'S NAME(S) (Please print) Group Policy# 5479448 Annual Salary: $

Last Name	First Name	Middle Initial	Relationship to Employee	%
Last Name	First Name	Middle Initial	Relationship to Employee	%

I confirm that the information I have provided on this form is complete and accurate.

(Employee Signature) **Date**

Dependent Enrollment Procedures 2018-2019

*This form and appropriate documentation **MUST BE SUBMITTED DURING THE ELIGIBILITY PERIOD** (within **31 days of the qualifying event**) before coverage will be effective. If all documents are not provided within the eligibility period (**31 days**) or during the open enrollment period (**31 days**), your dependents will not be covered this plan year. You will need to wait until the next open enrollment to add your dependent.*

Dependent children are eligible until the end of the month they turn age 26, regardless of marriage or student status. A dependent child's spouse or child is *NOT* eligible for coverage.

In order to enroll any dependents for coverage under your district's insurance plans, you must provide documents showing that they qualify for dependent status. The following outlines who qualifies as a dependent and what documents are required:

Please present the following documents to your District Treasurer's or HR Office:

Spouse: Your legally married (including same sex) spouse, not legally separated or divorced.

Documents required:

1) Marriage certificate that has been filed with court **AND**
2) First page of your most recent Federal tax form (1040) showing that you are still married. Please black out Social Security numbers and financial information to protect your financial privacy.

Children: You or your spouse's natural or adopted child and/or a child for whom you are the legal guardian. EPC coverage terminates the end of the month they turn age 26.

Documents required:

1) Birth certificate naming you / your spouse as the parent **OR**
2) Adoption papers naming you / your spouse as adoptee parents **OR**
3) Appropriate court documents naming the employee/spouse as the child's legal guardian.

PART I - Dependent Enrollment Affidavit

Please present the following documents to your District Treasurer's or HR Office:

Spouse:

- Marriage certificate **AND**
- Front page of the most recent federally filed tax return. Actual income numbers can be blacked out.

For Each Child:

- Birth certificate naming the employee/spouse as the child's parent ***OR***
- Adoption papers naming the employee/spouse as the child's adoptive parent ***OR***
- Appropriate court documents naming the employee/spouse as the child's legal guardian.

By my signature on this form, I certify and warrant to my employer that all information submitted is true, correct and current as of the date signed and any attempt to enroll for/or maintain coverage for an ineligible dependent will be subject to appropriate disciplinary action. I have provided the documentation for each eligible dependent as required. I understand I will be responsible for any claim payments made for ineligible dependents.

Signature of Employee (REQUIRED): _____ **Date:** _____

Please print Employee Name _____

Part II – Completion by HR/Treasurer Department

Please upload this affidavit and all required document(s) into staff member's file cabinet in Benelogic.

Dependent Name	*Spouse*		Children		
	Marriage Certificate	Recent Tax Form	Birth Cert	Adoption	Legal Guardianship

I have certified that all of the above has been reviewed and the dependents are eligible under the group benefit plan.

Signature of District HR/Treasurer's Department: _____

District: KETTERING CITY SCHOOL DISTRICT **Date:** _____