SISCO
experience the benefits

SECTION I – EMPLOYEE INFORMATION AND COVERAGE ELECTION

Employer Name	Group #	Payroll Cycle	Division	Plan

Name (First, MI, Last)	Social Security #_____-_____-_____	Hire Date _____/_____/_____
Street Address	**Telephone**	**Effective Date** _____/_____/_____

City State Zip	Date of Birth _____/_____/_____	Email address

❑ Male ❑ Female Marital Status ❑ Mar ried ❑ Single ❑ Divorced ❑ Legally Separated ❑ Widow/Widower

Medical	Dental	Vision
❑ Single	❑ Single	❑ Single
❑ EE/Spouse	❑ EE/Spouse	❑ EE/Spouse
❑ EE/1child	❑ EE/1 child	❑ EE/1child
❑ Family	❑ Family	❑ Family
❑ Decline	❑ Decline	❑ Decline

Reason for Completing this Form

- ❑ New Hire
- ❑ Late Enrollment
- ❑ Marriage/Birth/Adoption
- ❑ Terminate Coverage for one/all dependents
- List dependents who are no Longer covered _____
- ❑ Part/Full-time Change
- ❑ Special Enrollment/Loss of Coverage
  - Date Coverage lost _____
  - ❑Voluntary or ❑ Lost other coverage

Date of Event/Change _____/_____/_____

SECTION II – ELIGIBLE DEPENDENTS INFORMATION Note: This application does not guarantee coverage.

Name (First, MI, Last)	Relationship	Social Security # - (SSN) *Federal law MMSEA requires collection of SSN for all dependents*	Date Of Birth	Gender
Spouse	❑ Spouse (lawful) ❑ Common Law *if plan allows ❑ Other			❑ M ❑ F
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent	❑ Natural/Adopted ❑ Step Child ❑ Foster Child ❑ Other			❑ M ❑ F

DEPENDENTS OVER AGE 19
I have reviewed the dependent eligibility terms of the plan and the dependents listed below are eligible for coverage. I will advise my health plan of any changes that will affect their coverage.

Signature _____

Date _____

SECTION III – OTHER COVERAGE Note: This section must be completed for SISCO to process your dependent claims.

PART A: Spouse (if applicable) **Date of Marriage**

Name & City of Employer
_____

Does your spouse have other coverage with this employer?
☐ Yes ☐ No

If no, is he/she eligible for other coverage with this employer?
☐ Yes ☐ No

If your spouse does have other coverage through this employer,
1. Indicate the type of coverage:
   ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan _____
   _____

PART B: Ex-spouse (if applicable) **Divorce Date**

(*this information is for Coordination of Benefits for any dependent children)*
Ex-Spouse Name(s)_____
Address(es)

Social Security # (*if available*)_____

Name and City of Employer(s)
_____

If your ex-spouse has coverage through this employer,
1. Indicate the type of coverage:
   ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision
2. What date did this coverage become effective?
   _____
3. List the children covered under this plan _____
   _____

Does your spouse or any other dependents have Medicare? ❑ **Yes If yes, who?**_____ ❑ **No**
Are your spouse or any dependents disabled? ❑ **Yes If yes, who?**_____ ❑ **No**

SECTION IV – SIGNATURE TO ELECT OR DECLINE COVERAGE

Elect: *The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings (pre-tax if applicable). I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments, this auth will be used for verification of benefit eligibility and claim processing. This consent is subject to revocation at any time through a written submission to SISCO.*

Signature **Date**

Decline: *I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.*

❑ *I do have other coverage*
❑ *I do not currently have other coverage*

Signature **Date**