Employee Benefits Enrollment Application
(High Deductible Health Plan)

Instructions For Completion of Form

Application Requirements:

- Provide exact dates where requested (month, day and year).
- Use legal names for yourself and your dependents. Example: use the legal name "Elizabeth" instead of the familiar name "Beth".
- You must provide a social security number for each dependent (spouse or dependent children) that you are requesting to be added to your family program.
- You must provide the following documents, when applicable, before benefits can be started: proof of your marital status (marriage certificate), social security card for spouse and dependent children, birth certificate for dependent children, and legal custody paperwork for dependents other than natural children.
- You must provide all current employment and insurance information for any spouse or dependent children. Even if the current benefits are scheduled to terminate at a future date, they must be added to your application.

Application Instructions:

→ **Employee Data** ← Complete all information requested for you in the section "Employee Data".

→ **Information for Dependent** ← If you are electing family coverage, complete all information for the dependents you are requesting to be added to your family program under the "information for spouse'' section, the "Information for Dependent" section, or both. (If you are requesting the addition of a single dependent, and other dependents are currently enrolled under your program, you must supply information for all dependents).

→ **Benefit Election** ← Select benefits you are electing on the first page under "Benefit Election" section. (reminder – if you are not eligible for vision benefits do not complete the vision option). In the section provided, indicate the date you wish the benefits you are electing to begin. Benefits begin on the 1st or 15th of a month. Effective dates are determined either by request or by contractual eligibility – please be aware that it may not be possible to accommodate your requested effective date. If the date of benefits you request and the date that benefits may begin differ, you will receive an email to your District email account with the correct effective date provided to you.

If you currently have a benefit, and you are adding another type of benefit, make a selection for the benefit you currently have and the new benefit you are electing on the application form. (Example: if you currently have family medical insurance, and you are adding family dental insurance, circle "yes" to both medical and dental benefits and circle "family" for both benefits).

→ **Sign and Date** ← provide your legal signature and the current date at the bottom of the "Benefit Election" section.

→ **RETURN THIS FORM TO THE OFFICE OF HUMAN RESOURCES** – After the signature and date are completed, the form may be scanned and emailed, returned by school mail delivery, returned by U.S. Mail, or returned in person.

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→ *Employee Data* ←

Soc Security Number	SCSD ID #	Employee Last Name	Employee First Name	M.I.

Street Address

City	State	Zip Code	Date of Birth	Gender

Marital Status (Please Circle)	Date of Marriage	Home Telephone #	Work telephone #
☐ Married ☐ Divorced ☐ Single	___/___/___		

Preferred Email Address
Email Address:

Do you have other Health, Dental, Vision , Etc. Insurance? (do not include spousal coverage below)		If yes, provide the other insurance information below: ↙

Type	Name of Other Insurance	Start Date	Cancel Date	Coverage (please circle)
Health		___/___/___	___/___/___	Individual Family
Dental		___/___/___	___/___/___	Individual Family
Other		___/___/___	___/___/___	Individual Family

→ *Benefit Election* ←

I request enrollment in the following benefits:

Health Insurance (HDHP) – POMCO (please circle your choice):	Yes	No	Family	Individual	← ☐ Family ☐ Individual ☐ Waive — Code — Eff Date: __/__/__
Dental Insurance – POMCO (please circle your choice):	Yes	No	Family	Individual	← ☐ Family ☐ Individual ☐ Waive — Code — Eff Date: __/__/__
Vision Insurance – Davis (please circle your choice):	Yes	No	Family	Individual	← ☐ Family ☐ Individual ☐ Waive ☐ Not Eligible — Code — Eff Date: __/__/__

I request that benefits begin on the following date: ____/_____/_____ (the requested date must be the 1st or 15 of a month)

Office Use Only

Union:		Hire Date:	
Apt (10/12)		Job Title:	

Status (√):

☐ Active/Full-time ☐ Retired ☐ Survivor

☐ Miscellaneous _____

NW	CH	LT	TM	RT	RE
Health		Dental		Vision	

PSoft	POMCO	Word	Arrears
Invoice	Refund	Email : SCSD or Personal	

Notes:

_____

_____

_____

_____

_____

_____

- I certify that all information provided on this form is true and correct to the best of my knowledge and that I have read, understand, and agree to comply with the terms of the release below.
- I further acknowledge that I have been provided with adequate and appropriate explanation and information regarding the benefits I have requested above under "benefit election" and that I take responsibility to review, understand, and make inquiries as part of my enrollment in this plan.
- I understand that this application will be approved and processed for enrollment only after my eligibility has been confirmed by the Syracuse City School District. I understand my effective date of insurance is available to me from the Syracuse City School District and take responsibility for knowing that effective date as it relates to District benefits and other benefits outside the District I may have available to me. I am aware that the District policy regarding prepayment may require an adjustment to my paycheck
- deductions accordingly.
- Any person who knowingly and with intent to defraud any group health plan or other person, files an application for health coverage or statement of claim containing any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

_____ _____/_____/_____

Employee Signature Date

→ *Information for Spouse* ←

Spouse Last Name	Spouse First Name	M.I.	Spouse Date of Birth	Gender

Employed	Name of Spouse Employer	Disabled	Date Disabled	Does your spouse have Medicare	Spouse Social Security Number
Yes No		Yes No	___/___/___	Yes No	

Does your spouse have Health, Dental, Vision, Etc. Insurance?	Yes No	If your spouse has other medical, dental, or vision benefits provide that information below: ↙

Type of Benefit	Name of Other Insurance	Start Date	Cancel Date	Coverage (please circle)
Health		___/___/___	___/___/___	Individual Family
Dental		___/___/___	___/___/___	Individual Family
Other		___/___/___	___/___/___	Individual Family

→ *Information for Dependents* ←

#1	Dependent Last Name	First Name	M.I.	Date of Birth	Gender	Relationship to Employee	Employed?	Is Dependent a College Student?
				___/___/___			Yes No	Yes No

Is Dependent Disabled?	If disabled, give date of disability:	Does Dependent have Medicare?	Dependent Social Security Number	If Dependent is a College Student, Provide College Name:	Approximate Graduation Date
Yes No	___/___/___	Yes No			

Does this Dependent have any medical, dental, or vision benefits other than your POMCO or the spousal benefits you listed above?	Yes No	If yes indicate: Health Dental Vision

#2	Dependent Last Name	First Name	M.I.	Date of Birth	Gender	Relationship to Employee	Employed?	Is Dependent a College Student?
				___/___/___			Yes No	Yes No

Is Dependent Disabled?	If disabled, give date of disability:	Does Dependent have Medicare?	Dependent Social Security Number	If Dependent is a College Student, Provide College Name:	Approximate Graduation Date
Yes No	___/___/___	Yes No			

Does this Dependent have any medical, dental, or vision benefits other than your POMCO or the spousal benefits you listed above?	Yes No	If yes indicate: Health Dental Vision

#3	Dependent Last Name	First Name	M.I.	Date of Birth	Gender	Relationship to Employee	Employed?	Is Dependent a College Student?
				___/___/___			Yes No	Yes No

Is Dependent Disabled?	If disabled, give date of disability:	Does Dependent have Medicare?	Dependent Social Security Number	If Dependent is a College Student, Provide College Name:	Approximate Graduation Date
Yes No	___/___/___	Yes No			

Does this Dependent have any medical, dental, or vision benefits other than your POMCO or the spousal benefits you listed above?	Yes No	If yes indicate: Health Dental Vision