Syracuse City School District
Employee Benefit Enrollment Application

Employee Data

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

Street Address

City	State	Zip Code	Date of Birth	Gender	Marital Status	Date of Marriage

Preferred Email Address	Home/Cell Telephone Number

Benefit Elections

I request enrollment in the following benefits:

Health Insurance – Please select your choice	Yes	No	Individual	Family
Dental Insurance – Please select your choice	Yes	No	Individual	Family
Vision Insurance – Please select your choice	Yes	No	Individual	Family

I request that benefits begin on the following date:

- 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:	

Spouse Information

Spouse Last Name	Spouse First Name	M.I.	Spouse Date of Birth	Gender	Spouse Social Security #

Employed	Name of Spouse Employer	Disabled	Date Disabled	Does your spouse have Medicare

Dependent Information

1) Dependent Last Name	Dependent First Name	M.I.	Dependent Date of Birth	Gender	Dependent Social Security #

College Student	Name of college	Disabled	Date Disabled	Does your dependent have Medicare

2) Dependent Last Name	Dependent First Name	M.I.	Dependent Date of Birth	Gender	Dependent Social Security #

College Student	Name of college	Disabled	Date Disabled	Does your dependent have Medicare

3) Dependent Last Name	Dependent First Name	M.I.	Dependent Date of Birth	Gender	Dependent Social Security #

College Student	Name of college	Disabled	Date Disabled	Does your dependent have Medicare

Office Use Only

Event Type		Effective Date		Completed	BAS Election Confirmation
Notes					

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Application Instructions:

Provide exact dates where requested (month, day and year) and use legal names for yourself and your dependents. Example: use the legal name "Elizabeth" instead of the familiar name "Beth".

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.

Other Insurance Coverage: It is not unusual to find yourself or your dependents covered by two health insurance plans/policies. When this is the case, to ensure claims are designated correctly to each insurance, please notify Excellus at 888/205-3154.

Employee Data: Complete all information requested for you in the section "Employee Data" (page 1).

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. If you currently have a benefit, and you are adding another type of benefit, select the benefit(s) 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, select "yes" to both medical and dental benefits and select "family" for both benefits) (page 1).

Information for Dependent: If you are electing family coverage, complete all information for the dependent(s) enrolling in coverage under the "information for spouse'' section, and/or the "Information for Dependent" section (page 2).

Sign and Date: Provide your legal signature and the current date at the bottom of the "Benefit Election" section.

Benefit Start Date:

New Employee: Benefits begin the first of the month following your hire date.

- New employee applications must be completed and returned to the Office of Human Resources within 30 days of your hire date.

Qualifying Event: Benefits begin effective the date of your event.

- Qualifying event applications must be completed and returned to the Office of Human Resources within 30 days of your event date. Examples of qualifying events include but are not limited to marriage, loss of other coverage, the birth of a child, and divorce.

Annual Enrollment: Benefits begin July 1 of the following plan year.

- Annual enrollment applications must be completed and returned to the Office of Human Resources during the 30-day annual enrollment period designated by the District.