CITY SCHOOL DISTRICT OF ALBANY—BENEFITS ENROLLMENT APPLICATION

EMPLOYER USE ONLY

Group Name

Group No. | Sub Group #

Effective Date Requested _____/_____/_____

SECTION 1

Your Last Name | First | M.I.

Address

City | State | Zip Code

If married/domestic partner, is it with an employee of the District? ❑ Yes ❑ No

Your Social Security No. _____

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage _____/_____/_____ Date of Divorce _____/_____/_____

Phone No.: (_____)_____

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment _____/_____/_____ Date of Retirement _____/_____/_____

SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage from _____ to _____ (check new coverage)

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information:

REASON:_____

Type	Plan Code(s)	Individual	2 Person	Family	Complement to Medicare
Empire PPO w/Rx		❑	❑	❑	❑
Empire PPO w/ESI (retired prior to 2000)		❑	❑	❑	❑
CDPHP HMO		❑	❑	❑	❑
Dental PPO		❑	❑	❑	❑
Dental HMO		❑	❑	❑	❑
Vision (VSP)		❑	❑	❑	❑

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family? ❑ No ❑ Yes

If Yes; Policyholder Name | Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number | Birthdate _____/_____/_____

Insurance Co. Name | Policy #

Address

Plan Type ❑ Self Only ❑ Self and Family **Coverage Type** ❑ Health ❑ Drug ❑ Dental ❑ Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

SECTION 4

ADD	DELETE	Relationship	DEPENDENT NAME Last First M.I	Birthdate	Social Security#	Copy of Medicare card required Medicare A & B	Disabled?	FOR CDPHP EPO AND EMPIRE PPO ENROLLMENT ONLY Primary Physician - OB/GYN	Existing Patient ✓
❑	❑	**Self** ❑ M ❑ F		___/___/___	___-___-___	___/___/___ ___/___/___	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Husband ❑ Wife ❑ Domestic Partner		___/___/___	___-___-___	___/___/___ ___/___/___	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	___-___-___	___/___/___ ___/___/___	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	___-___-___	___/___/___ ___/___/___	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	___-___-___	___/___/___ ___/___/___	❑ Yes ❑ No	PCP / OB/GYN	

SECT. 5

Do your dependents reside in your home? ❑ Yes ❑ No If No give address:

List names | Address

Applicant's Signature _____ Date _____

Employer's Signature _____

Date _____/_____/_____