

OSBA EMPLOYEE ENROLLMENT FORM



FOR EMPLOYER USE ONLY:
Group No. 092000 _____
Package No. _____
Requested Effective Date _____
FOR PLAN USE ONLY:
Alternate ID Number _____

School District _____

- New Enrollment - Date of Full-Time Hire/Rehire (mm/dd/yyyy) _____
 Change of Existing Enrollment

Please complete all information on this form:

Employee's Last Name *	Employee's First Name *	Middle Initial	e-mail address	Social Security No.	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address & Apt. No./Mailing Address	City	State	Zip Code	Home Phone ()	Business Phone ()	<input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widow

Dependents to be enrolled:

Plan Use	Full Last Name *	Full First Name *	Middle Initial	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender M/F	Relationship to Employee	Enrolling in:
Employee 1	Same as Above	Same as Above	Same	Same as Above	Same as Above	Same	Self	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Spouse 2					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 3					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 4					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 5					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 6					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 7					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental

* List names as they should appear on your identification card.

If changing existing enrollment, indicate reason below:

<input type="checkbox"/> Name Change - Former name _____	<input type="checkbox"/> Add Dependent due to:	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Delete Dependent - Reason _____
<input type="checkbox"/> Address Change	<input type="checkbox"/> Marriage - Date _____	<input type="checkbox"/> Newborn	Name(s) _____
	<input type="checkbox"/> Loss of Coverage - Date _____	<input type="checkbox"/> Other _____	If applicable - Final date of divorce _____

List any of the above dependent(s) attending a boarding school, accredited college or university. Include the name and location of the school.

If you are applying due to loss of other health insurance coverage, please include a copy of your certificate of coverage and complete the following:

Policy No.	Identification No.	Name of Insurance Company/Phone No.	Date Coverage Began	Date Coverage Ends
Coverage was: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medical <input type="checkbox"/> Dental For: <input type="checkbox"/> Self Only <input type="checkbox"/> Family as listed above <input type="checkbox"/> Other _____			Reason for Loss of Coverage	

