

# CONSORTIUM CUSTOM HEALTH PLAN

## ELIGIBILITY FORM

DISTRICT NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

- Initial Enrollment     
  Open Enrollment     
  Change
- Addition       Name       Address  
 Deletion       COBRA       AB528

### Enrollee Information

Social Security No.		Effective Date:	
Last:	First:	MI:	Birth Date:
Address:		Zip Code:	Phone No.:
Occupation:		<input type="checkbox"/> Active – Date of Employment:	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Terminated – Date of Termination:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced		<input type="checkbox"/> Retired – Date of Retirement:	
<input type="checkbox"/> Married/Declaration of Domestic Partner Date:		<input type="checkbox"/> Divorced/Dissolution of Domestic Partner Date:	

### Dependent Information

Last Name <small>(Spouse/Registered Domestic Partner)</small>	First	MI	Social Security Number	Sex <small>(M)(F)</small>	Birthdate
(Child)					
(Child)					
(Child)					
(Child)					

**DID YOU OR YOUR COVERED DEPENDENTS HAVE OTHER INSURANCE PRIOR TO YOUR DATE OF EMPLOYMENT?**      YES     NO

**DO YOU OR YOUR COVERED DEPENDENTS HAVE ANY OTHER INSURANCE?**    YES     NO

Employee or Dependent	Employer	Insurance Company/ Telephone Number	Effective Date	I.D. Number

I am     My Spouse/Domestic Partner    is Currently Enrolled in Medicare

**TO BE SIGNED BY APPLICANT:**

Authorization is hereby given for payroll deduction for the applicable plan cost, if any. Authorization is also given to all providers of health care services, upon request from Plan claims administrator, to furnish information concerning services provided to me or my family for claims processing.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_