

EMPLOYEE DATA INFORMATION

EMPLOYER OF INSURED: MACOMB INTERMEDIATE SCHOOL DISTRICT

GROUP NUMBER: 1032

PLAN ADMINISTRATOR: Group Benefit Services, Inc.

THIS SECTION MUST BE COMPLETED IN FULL (Please Print or Type)			
EMPLOYEE NAME			
(last)	(first)	(middle)	
MAILING ADDRESS		SOCIAL SECURITY NUMBER	
CITY STATE, ZIP CODE		TELEPHONE NUMBER	
BIRTHDATE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>
Date of Employment: _____ Current Job Classification: _____			
Are you eligible for Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you have any other employers? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, indicate name and address on reverse side.			

THIS SECTION FOR SPOUSE INFORMATION ONLY (If you are married — this must be completed)			
SPOUSE'S NAME			
(last)	(first)	(middle)	
BIRTHDATE		SOCIAL SECURITY NUMBER	
Is your spouse employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, indicate name and address on reverse side.			
Does your spouse have medical, dental, and/or vision coverage through his/her employer? Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, REVERSE SIDE MUST BE COMPLETED IN FULL.			
Is your spouse eligible for Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>			

THE FOLLOWING MUST BE COMPLETED IN FULL

If your spouse and/or dependents are to be covered, please list below: (PLEASE PRINT OR TYPE)

FIRST AND LAST NAME	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE	BIRTHDATE

COVERAGE (Please check appropriate boxes)	Employee		Spouse		Dependents		Effective Date
	YES	NO	YES	NO	YES	NO	
Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Employee Signature: _____ Date: _____

Authorized Signature: _____ Date: _____

Spouse Insurance Coverage

Name of Employer: _____

Address: _____

_____ Zip _____

Telephone: _____

Name of Insurance Carrier(s):

Health: _____

Dental: _____

Vision: _____

Dependent Insurance Coverage

Name of Insurance Carrier(s):

Health: _____

Dental: _____

Vision: _____

If parents are divorced or legally separated, has dependent(s) coverage through any other insurance carrier(s):

Yes No

If yes, please **complete** the questions below:

Relationship to Dependent: _____

Date of Birth of Parent: _____

Name of Insurance carrier(s):

Health: _____

Dental: _____

Vision: _____

Additional information that may be beneficial:

