UNIFIED Group Services (800-291-5837) *ENROLLMENT FORM*

Employer: Muncie Community Schools

EFFECTIVE DATE	JOB TITLE/WORK LOCATION

EMPLOYEE INFORMATION

LAST	FIRST	MI	MALE ❑ FEMALE ❑	SINGLE ❑ MARRIED ❑

SOCIAL SECURITY#OF EMPLOYEE	DATE OF BIRTH	CONTACT NUMBER

ADDRESS

TYPE OF COVERAGE REQESTED:

MEDICAL ❑ EMPLOYEE ONLY ❑ EMPLOYEE+1 ❑ FAMILY ❑ NO COVERAGE

DENTAL ❑ EMPLOYEE ONLY ❑ EMPLOYEE+SPOUSE ❑ MEMBER+CHILD(REN) ❑ FAMILY ❑ NO COVERAGE

VISION ❑ EMPLOYEE ONLY ❑ EMPLOYEE+1 ❑ FAMILY ❑NO COVERAGE

COVERED MEMBERS

NAME	RELATIONSHIP	SOC SEC NUMBER	DATE OF BIRTH	❑MALE ❑ FEMALE	MEDICAL	DENTAL	VISION

OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health Insurance including Medicare? Yes ❑ No❑

If "Yes" to Medicare, please check all coverages that are applicable: Part A ❑ Part B ❑

If YES, what types of benefits are covered? MEDICAL ❑ RX ❑ DENTAL ❑ VISION ❑

If YES: Name of Insured Person:	Birthdate of Insured Person:	Covered Dependents:

Insurance Company Name:

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature *Date*

To be completed by Employer:

❑ New Enrollment_____

❑ Open Enrollment_____

❑ Cancellation_____

❑ Name Change – Formerly_____

❑ Change Dependent Status

_____

❑ Date Change Occurred_____