CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Drive West, Albany, NY 12205 enrollments@amsureins.com

GROUP NAME _____

SECTION A

Last Name | First | M.I.

Address | County

City | State | Zip Code

Your Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

Phone No.: (_____)_____ (_____)_____

Employment Status: ☐ FT ☐ PT Hrs/Weekly_____ ☐ Active ☐ Retired ☐ COBRA

Hire Date _____ / _____ / _____ Status Chg Date _____ / _____ / _____

EMPLOYER USE ONLY

Effective Date

_____ / _____ / _____

Retire Date _____ / _____ / _____

Grp No._____

Loc. Code_____

SECTION B

- ☐ Open Enrollment (complete Section D)
- ☐ New Enrollment/Reinstatement (complete Section D)
- ☐ Change Coverage to (check new coverage)
- ☐ Cancel Coverage (check what applies)
- ☐ Add/Delete Dependent (complete section D)
- ☐ Information Change (complete Section A)
- ☐ Waive Coverage (must provide proof of Insurance)
- ☐ NYS Dependent Coverage up to Age 29

	Carrier	Tier
Indem/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
PPO/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
POS/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
CDPHP EPO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
MVP HMO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Rx		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Dental		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Other		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr

Reason/Comments:

SECTION C

Other Coverage?

Is there coverage under any other group health plan available to you or any of your covered dependents?

☐ **Yes** ☐ **No**

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

Social Security Number | Birth Date

_____ / _____ / _____ _____ / _____ / _____

Insurance Co. Name | Policy #

Plan Type ☐ Self only ☐ Self/Spouse ☐ Self/Child(ren) ☐ Fam

Coverage Type ☐ Health ☐ Drug ☐ Dental ☐ Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below)

SECTION D

ADD	DELETE	Relationship	Last First M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date (Copy of Medicare card required)	MVP HMO & BS POS ONLY Primary Care Physician (PCP)
☐	☐	**Self** ☐ M ☐ F		___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	**Spouse/DP** ☐ M ☐ F		___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	

SECTION E

Do your dependents reside in your home? ☐ Yes ☐ No

If No, give address:_____

Do you have a disabled dependent beyond age 19? ☐ Yes ☐ No

List name(s):_____

Full-time college students age 19 and over (Dental Only):

List Names: School Name and Address:

_____ _____

_____ _____

_____ _____

Dependent Verification*

School District Representative (SDR) _____ (please initial)

Date: _____

* The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).

Applicant's Signature: _____

Date: _____

Employer's Signature: _____

Date: _____

White Copy – AMSURE Yellow Copy – EMPLOYER Pink Copy – EMPLOYEE

GENERAL AUTHORIZATION

My signature on this form authorizes my employer to make any required payroll deductions.

All information furnished hereon is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. I hereby authorizer my employer to make any required payroll deductions.

I understand that the benefits for which I will be eligible are in accordance with those described in the applicable carrier contract/certificate and any attached riders.

I understand that unresolved grievances are subject to the procedure specified in the respective carrier contract/certificate and in coordination with that which is deemed applicable by DFS law.

I the undersigned hereby authorize the use and disclosure of personal health information as necessary, and as permitted by law. I understand that Amsure, a division of ATCFSI is required by law to maintain the privacy of personal health information as required by law regarding the privacy practices with respect to personal health information.