ENROLLMENT/ CHANGE FORM

BENEFIT SERVICES, INC.
3636 Copley Road, P.O. Box 4138, Akron, OH 44321
(330) 666-0337 - FAX (330) 666-6685

[ ] New Enrollment Effective: _____ /_____ /_____
[ ] Change [ ] Termination Effective: _____ /_____ /_____ Reason for Change: _____

NAME OF EMPLOYER: MT. VERNON CITY SCHOOLS		DEPARTMENT:	
NAME OF EMPLOYEE:	Last:	First:	Middle:
ADDRESS:	Number & Street:		Apt. #:
City:	State:	Zip:	Phone:

[] Male [] Female	[] Active [] Retired [] Medicare	Hire/Rehire Date: / /	Date of Birth: / /	Social Sec. #: – –	[]single []widowed []married []divorced DATE: / /

PLEASE COMPLETE ALL APPLICABLE BENEFIT SELECTIONS

I am enrolling/enrolled in:	SINGLE	FAMILY
Medical & Rx		
Dental		

I want to change to:	SINGLE	FAMILY
Medical & Rx		
Dental		

Are you or any of your dependents considered totally disabled? _____yes _____no

DEPENDENTS

Eligible Dependents: Last Name	First Name	Initial	Social Security #	Relationship*	Birth Date	Sex	Other Insurance:
Spouse:			/ /		- -	[]M []F	[]Yes []No
**Child:			/ /		- -	[]M []F	[]Yes []No
**Child:			/ /		- -	[]M []F	[]Yes []No
**Child:			/ /		- -	[]M []F	[]Yes []No
**Child:			/ /		- -	[]M []F	[]Yes []No

* Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify).
** Proof of dependent eligibility may be required.

OTHER INSURANCE

Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: [] Individual [] Family
Spouse - Policy Holder's Name:	Insurance Company Name:	Coverage is: [] Individual [] Family
Child's - Policy Holder's Name:	Insurance Company Name:	Coverage is: [] Individual [] Family

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Benefit Services, Inc. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information

Signature of Employee _____ Date Signed _____

COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: [] Medical & Rx [] Dental

Signature of Employee _____ Date Signed _____

Signature of Employer _____ Date Signed _____