Administered by
SIEBA, LTD.
111 GRANT AVE, SUITE 202
PO BOX 5000
ENDICOTT, NY 13761-5000

EDEN II BENEFITS ENROLLMENT FORM

OFFICE USE	DATE RECEIVED

OFFICE USE ONLY	
GROUP #	
UNIT #	
EFFECTIVE DATE	
BY	

☐ **HIGH MEDICAL** ☐ **LOW MEDICAL**

☐ **DECLINING COVERAGE**
(Signature Required at the bottom of this form if declining coverage)

☐ **Employee Only**
☐ **Employee + One**
☐ **Employee + Family**

Employee Information

LAST NAME | FIRST | INITIAL | SOCIAL SECURITY NUMBER ___ - __ - ____

STREET ADDRESS

CITY | STATE | ZIP CODE | EMAIL ADDRESS ______________________________@_________

SEX (circle) MALE FEMALE | DATE OF BIRTH | HIRE DATE | CURRENT MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

DEPT NAME/LOCATION | HOME OR CELL PHONE# ( ) | WORK PHONE# ( )

BELOW , LIST YOUR SELF, YOUR SPOUSE/DOMESTIC PARTNER AND ELIGIBLE DEPENDENTS THAT YOU CAN CLAIM as a DEPENDENT ON YOUR INCOME TAX RETURN.

Dependent Information

LAST NAME	FIRST NAME	Date of Birth	Relationship ie spouse, son, etc	Social Security #	Primary Care Physician
			SELF		

Primary Care Physician

Other Health Coverage

IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES NAME OF SPOUSE'S EMPLOYER___________________________

DOES YOUR SPOUSE HAVE OTHER GROUP INSURANCE? ☐ NO ☐ YES - CHECK ALL THAT APPLY BELOW

NAME OF CARRIER____EFFECTIVE DATE OF COVERAGE_____________________________

MEDICAL COVERAGE	DENTAL COVERAGE	VISION COVERAGE
☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY

ARE **YOU** COVERED BY MEDICARE? (Either as Primary or Secondary) ☐ NO ☐ YES **(Must attach copy of Medicare Card)**

IS **YOUR SPOUSE** COVERED BY MEDICARE? (Either as Primary or Secondary) ☐ NO ☐ YES **(Must attach copy of Medicare Card)**

Dependent Children

IS THERE A COURT ORDER FOR HEALTH COVERAGE RESPONSIBILITY? ☐ NO ☐ YES - ATTACH A COPY

IF THERE ARE STEP CHILDREN, WHO HAS CUSTODY OF THEM? ☐ MOTHER ☐ FATHER ☐ JOINT

IF YOUR SPOUSE DOES NOT HAVE SOLE CUSTODY, ANSWER THE QUESTIONS BELOW.

DOES THE PARENT WITH CUSTODY HAVE OTHER HEALTH COVERAGE FOR THESE CHILDREN? ☐ NO ☐ YES

NAME OF CARRIER____

☐ MEDICAL COVERAGE ☐ DENTAL COVERAGE ☐ VISION COVERAGE

NAME OF OTHER PARENT____DATE OF BIRTH_____/_____/_____

All information furnished hereon is true and complete to the best of my knowledge. If a contribution to the above named Plan(s) is required, I authorize the deduction from my earnings.I acknowledge that I have provided EDEN II with the appropriate Affidavit of Domestic Partnership if I am requesting benefits from this Plan for my domestic parter. I also understand the tax consequence of receiving benefits from this Plan for my domestic partner. If I have declined coverage, I understand that I will not be able to elect again to enroll in the EDEN II Group Medical Plan unless I have a qualifying change of status or during the the next open errollment period. I also understand that this health plan includes a voluntary Care Management program, that I am required to obtain precertification for certain medical services, and that I may be contacted by a Care Management nurse as a part of my election of this health plan.

SIGNATURE____DATE____________________________