Cumberland School District

Group Enrollment Form – Bind/United Healthcare

EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Change	First Name (Legal Name*) M.I. Last Name			Social Security Number (Required)
	Street address Apt/Box # City County State Zip			
Email Address:			Birth date (mm/dd/yyyy)	Marital Status: ☐ Married ☐ Single Disabled: ☐ Yes ☐ No
Home phone	Cell phone	Gender M ☐ F ☐		Coverage begin date (mm/dd/yyyy)

DEPENDENT INFORMATION

Legal Name*: First Name M.I Last Name	Birth date: (mm/dd/yyyy)	Social Security# (Required) The number is used for IRS tax reporting regarding your health plan.	Relationship (Spouse, son, daughter)	Sex M/F	Is this person Disabled? Yes/No

*Legal name is the name stated on their Social Security Card, if they have one.

WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1) I understand I am eligible for coverage through my employer. I DO NOT want coverage for:
☐ Me and my dependents ☐ My spouse ☐ My dependents only

2) The reason I am declining coverage at this time is because I or my dependent(s) have coverage provided through:
☐ Spouse's Group Plan ☐ Medicare ☐ Other: _____

Employee Signature: X_____ Date signed: _____

(only sign if you are waiving coverage)

COORDINATION OF BENEFITS

BIND will request information from you. Failure to complete that document may result in a delay in the processing of your claims. This includes any other health insurance or medical coverage, including Medicare.

EMPLOYEE AUTHORIZATION & REPRESENTATION

Applicant's Statements and Agreements: I attest that the information provided above is true and correct to the best of my knowledge and false information may result in the denial of claims or cancellation or retroactive termination of coverage. Any person(s) who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above. This agreement is subject to the terms of the employer's section 125 cafeteria plan and governed in accordance with all applicable laws. I understand that the coverage I have elected will be deducted on a pre-tax basis from my pay (if applicable). I understand these rules and have elected to participate in the program(s) as indicated above:

Employee Signature: X_____ Date signed: _____