CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Dr West, Albany, NY 12205 - (518) 689-1555, emorrissette@amsure.net

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

SECTION D

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

Copy of Medicare card required

MVP HMO & BS POS ONLY

ADD	DELETE	Relationship	Last	First	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date	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	___/___/___	___/___/___ ___/___/___	

SECT 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