INDECS CORPORATION
1099 Wall Street West, Lyndhurst, NJ 07071
1 (888) 4-INDECS (446-3327)
Fax (201) 460-3204

Form #OUSD-4510E-3/09

ENROLLMENT

ORANGE - ULSTER SCHOOL DISTRICTS HEALTH PLAN

Print Form

For Enrollment Only
Check Type:
☐ Initial ☐ Reinstatement

ENROLLEE'S SCHOOL DISTRICT: ________

ENROLLEE/MEMBER INFORMATION

Last Name ____ First Name ____ Initial ____ SSN ____ DOB M M D D Y Y Y Y Sex ☐M ☐F

Street Address ____ City ____ State ____ Zip Code ____ Marital Status: ☐Single ☐Married ☐Divorced ☐Legally Separated

COVERAGE: Type: ☐ Individual (skip to Other Coverage section) ☐ Family (fully complete form)

☐ Active ☐ Retired ☐ Surviving Spouse

Date of Marriage/Divorce or Legal Separation M M D D Y Y Y Y

When applying for other than individual coverage, list all eligible dependents. Indicate relationships by selecting choices from drop down box. (If other, detail in remarks and submit legal documentation.) Complete additional family information form if space is insufficient.

Spouse's SSN is required.

Spouse / Dep/Relationship	First Name	MI	Last Name (If different)	Date of Birth M M D D Y Y	SSN	Full-Time Student	Handicapped
Spouse							
Dep/Relationship						☐Yes ☐No	☐Yes ☐No
Dep/Relationship						☐Yes ☐No	☐Yes ☐No
Dep/Relationship						☐Yes ☐No	☐Yes ☐No

☐ More dependents, complete Enrollment Continuation on next page ☐ Other, complete remarks Remarks: ____

CERTIFICATE OF COVERAGE/PLAN DESCRIPTION INFORMATION

Federal regulation require that your covered dependents be notified of certain Plan provisions. You must indicate that you will send a copy of your Certificate of Coverage to all other Plan beneficiaries, or indicate where Certificate of Coverage information is to be sent.

☐ I will convey coverage information, or ☐ send additional info to: Name ____ Email ____

Street Address ____ City ____ State ____ Zip Code ____

OTHER COVERAGE INFORMATION

Are there any other hospital, medical or group health benefits provided to you, your spouse or other dependents which furnish services or similar coverage to those for which you are enrolling? ☐ Yes ☐ No If yes, complete the following:

Person with other coverage:	Single	Family	ID or Group No.	Plan Name-Address	Effective Date
	☐	☐			

AUTHORIZATION/CERTIFICATION

I understand that the Plans and coverages listed above shall be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent disclosures are punishable by law. ***(PRINT, SIGN and DATE ORIGINAL.)***

Print Name ____ Signature ____ Current Date **9/18/13**

LOCAL ADMINISTRATORS - (MUST BE COMPLETED)

Enrollee's Hire Date ____ Coverage Effective Date ____

I certify that I have the original of this document, signed by the Enrollee, which will be maintained by this District.

Print Name ____ Signature ____ Current Date **9/18/13**

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Form #OUSD-4510E-2/06

ENROLLMENT Continuation

ORANGE - ULSTER SCHOOL DISTRICTS HEALTH PLAN

Print Form

For Enrollment Only
Check Type:
☐ Initial ☐ Reinstatement

ENROLLEE'S SCHOOL DISTRICT:

Dep/Relationship	First Name	MI	Last Name	Date of Birth (M M D D Y Y)	SSN	Full-Time Student	Handicapped
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

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LOCAL ADMINISTRATORS - (MUST BE COMPLETED)

Enrollee's Hire Date | Coverage Effective Date

I certify that I have the original of this document, signed by the Enrollee, which will be maintained by this District.

Print Name | Signature | Current Date **9/18/13**