INDECS
A HOMESTEAD COMPANY
1099 Wall Street West
Suite 317
Lyndhurst, NJ 07071
1 (888) 4-INDECS (446-3327)
Fax (201) 460-3204

CHANGE

OU Health

SELECT SCHOOL DISTRICT

PRINT

To change existing enrollee/dependent information only. DO NOT use for termination or deletion.

Last Name | First Name | MI | Social Security No.

CHECK THE SECTION TO BE CHANGED

ENTER THE EFFECTIVE DATE

COMPLETE THE NEW DATA ONLY INSERTING THE "CHANGE TO" INFORMATION

ENROLLEE/MEMBER INFORMATION

CHANGE ☐ PART 1

Last Name | First Name | MI | Social Security No. | Date of Birth | Sex ☐ M ☐ F

Address | City | State | Zip Code | Date of Marriage/Divorce or Legal Separation

Home Phone # (Required) | Email Address (Required) | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Mobile Phone # (Required)

COVERAGE

CHANGE ☐ PART 2

Effective Date

TYPE: ☐ Individual (skip to Part 4) ☐ Family (complete Parts 3, 4 & 5) ☐ 2 Person (complete Parts 3, 4 & 5)

STATUS: ☐ Active ☐ Retired ☐ Medicare

FAMILY INFORMATION

CHANGE ☐ **ADD** ☐ **BOTH** ☐ PART 3

When applying for other than Individual Coverage, list all eligible Dependents. (If other, detail in remarks and submit legal documentation.)

Spouse ☐ M ☐ F | First Name | MI | Last Name (if different) | Date of Birth | SSN (Spouse's SSN Required) | Effective Date

Dep ☐ M ☐ F

Dep ☐ M ☐ F

OTHER COVERAGE INFORMATION

☐ PART 4

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: ☐ S ☐ F | ID or Group No. | Plan Name & Address | Effective Date

MISCELLANEOUS

☐ PART 5

Detail any changes not covered by this form, or use this area to clarify any of the above changed information. 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 & DATE ORIGINAL)***

Current Date

Print Name | Signature

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.

Current Date

Print Name | Signature

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CHANGE Continuation

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ENROLLEE/MEMBER INFORMATION

Last Name | First Name | MI | Social Security No. | Date of Birth | Sex ☐M ☐F

Address | City | State | Zip Code

Home Phone # (Required) | Email Address (Required) | Marital Status: ☐Single ☐Married ☐Divorced ☐Legally Separated

(Required)

FAMILY INFORMATION

CHANGE		First Name	MI	Last Name (if different)	Date of Birth	SSN (Spouse's SSN Required)	Effective Date
☐	Spouse ☐M ☐F						
ADD ☐	Dep ☐M ☐F						
BOTH ☐	Dep ☐M ☐F						
	Dep ☐M ☐F						
	Dep ☐M ☐F						
	Dep ☐M ☐F						

Remarks:

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