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

ENROLLMENT

OU Health

SELECT SCHOOL DISTRICT

PRINT

For Enrollment Only

Check Type:

☐ Initial ☐ Reinstatement

ENROLLEE/MEMBER INFORMATION

Last Name | First Name | MI | Social Security Number | Date of Birth | SEX ☐ M ☐ F

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

COVERAGE: Type: ☐ Individual ☐ Family (fully complete form) ☐ 2 Person ☐ Active ☐ Retired ☐ Surviving Spouse

Date of Marriage/ Divorce or Legal Separation

Home Phone # **(Required)**

Mobile Phone # **(Required)**

Email Address **(Required)**

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 ☐ Male ☐ Female | First Name | MI | Last Name (if different) | Date of Birth | Spouse's SSN is required. | SSN

Dep/Relationship ☐ Male ☐ Female Relationship | SSN

Dep/Relationship ☐ Male ☐ Female Relationship | SSN

Dep/Relationship ☐ Male ☐ Female Relationship | SSN

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

CERTIFICATE OF COVERAGE/PLAN DESCRIPTION INFORMATION

Federal regulation requires 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 & DATE ORIGINAL)***

Print Name | Signature | Current Date

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

INDECS
A HOMESTEAD COMPANY

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

ENROLLMENT Continuation

OU Health

SELECT SCHOOL DISTRICT

PRINT

For Enrollment Only

Check Type:

☐ Initial ☐ Reinstatement

Social Security Number

Last Name First Name MI

Dep/Relationship	First Name	MI	Last Name (if different)	Date of Birth	
☐ Male ☐ Female Relationship					SSN
Dep/Relationship ☐ Male ☐ Female Relationship					SSN
Dep/Relationship ☐ Male ☐ Female Relationship					SSN
Dep/Relationship ☐ Male ☐ Female Relationship					SSN
Dep/Relationship ☐ Male ☐ Female Relationship					SSN
Dep/Relationship ☐ Male ☐ Female Relationship					SSN

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