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

Form #OUSD-4510E- 9/17

ENROLLMENT

OU Health

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) | 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)

Phone # | Email Address

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.

	First Name	MI	Last Name (If different)	Date of Birth (M M D D Y Y)	SSN
Spouse ☐ Male ☐ Female					Spouse's SSN is required.
Dep/Relationship ☐ Male ☐ Female					
Dep/Relationship ☐ Male ☐ Female					
Dep/Relationship ☐ Male ☐ Female					

☐ 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

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

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☐ Initial ☐ Reinstatement

ENROLLEE'S SCHOOL DISTRICT:

Last Name | First Name | Initial | SSN

Dep/Relationship	First Name	MI	Last Name	Date of Birth (M M D D Y Y)	SSN
☐ Male ☐ Female					
☐ Male ☐ Female					
☐ Male ☐ Female					
☐ Male ☐ Female					
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