NORTHWESTERN LOCAL SCHOOL DISTRICT

SUPER MED PLUS #-603406025 DRUG #-603406025 LIFE #-610712-0054 DENTAL #-212809-001

1. (Please Print)

LAST NAME | FIRST NAME | M. I.

STREET ADDRESS

CITY | STATE | ZIP CODE

PHONE NUMBER | DATE OF BIRTH | SOCIAL SECURITY NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐SEPARTED ☐ DIVORCED ☐ WIDOWED IF MARRIED-DATE / /

2 YOUR DEPENDENTS

	FIRST NAME	LAST NAME	Social Security #	Date of Birth	Gender M / F	Child / Stepchild Other
Spouse						Spouse
1						
2						
3						
4						

3. MEDICAL QUESTIONS

HAVE YOU OR ANY OF YOUR DEPENDENTS EVER BEEN TREATED FOR A SERIOUS MEDICAL CONDITION SUCH AS HEART DISEASE, CANCER, DIABETES, TRANSPLANTS, NERVOUS SYSTEM AND MUSCLE DISORDER, AIDS OR AIDS RELATED COMPLEXES OR MENTAL DISORDERS?
YES ☐ NO ☐ IF YES...MUST PROVIDE EXPLANATION OF CONDITION AND INCLUDE ANY PRESCRIBED MEDICATIONS.

4 OTHER HEALTH INSURANCE AND MEDICARE

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? YES ☐ NO ☐ IF YES, COMPLETE THE SECTION BELOW

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE CO.	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
				Hospitalization ☐ Drug ☐ Dental ☐	☐ Active ☐ Retired	☐ Single ☐ Family

MEDICARE INFORMATION:

Are you covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. _____ EFF. DATE: PART A: / / /

PART B: / / / ☐ Hemodialysis

Is your spouse or dependent covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. _____EFF. DATE: PART A: / / /

PART B: / / / ☐ Hemodialysis

5. LIFE INSURANCE -- Group Term **Select one - - *$50,000* *or* *$70,000***

Beneficiary Last Name	Beneficiary First Name	Date of Birth	Relationship	Benefit Split **
Primary				%
Secondary				%

** Unless otherwise noted, if two primary beneficiaries are named, the proceeds will be paid in equal shares to the primary beneficiaries surviving you.

6. SIGNATURE – Sign after completing and reading all applicable sections.

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated full-time employee and that the information I have provided is true and complete to the best of my knowledge.

_____ _____

Your Signature **Date**

TREASURER'S OFFICE USE ONLY

EFFECTIVE DATE OF COVERAGES_____

COVERAGES **"PLUS " ☐ SINGLE ☐ FAMILY** **DENTAL ☐ SINGLE ☐ FAMILY**
DRUG ☐ SINGLE ☐ FAMILY **LIFE ☐**