

**EDCARE GROUP**  
**GROUP HEALTH PLAN ENROLLMENT FORM**

**EMPLOYEE ENROLLMENT**

Male  
 Female

\_\_\_\_\_  
Last Name                                      First Name                                      MI                                      Social Security Number

\_\_\_\_\_  
Complete Address – (Street # & Name, City, State, Zip Code)                                      Date of Birth

Date of Hire \_\_\_\_\_ Effective Date (leave blank) \_\_\_\_\_

**FOR EMPLOYER USE ONLY:**     Kingsburg Elementary     Fowler Unified     State Center CC

New Hire                       Change only    If a change, prior coverage was through \_\_\_\_\_

Date of Employment \_\_\_\_\_                                      Coverage Effective Date \_\_\_\_\_

**BENEFIT ELECTION**

I elect the following coverage:                                       I decline coverage for: (Please read and sign the “Waiver of Coverage”  
 Modern Care Medical Plan                                       Myself                                      section at the bottom of this form)  
 Dental Plan (through Central Valley Dental Partners)                                       Spouse  
 Vision Plan (through Vision Service Plan)                                       Children  
 Spouse and Children  
Reason: \_\_\_\_\_

**DEPENDENT ENROLLMENT (Complete for each eligible dependent)**

SPOUSE’S EMPLOYER: \_\_\_\_\_

Relationship	First and Last Name	SSN	Date of Birth	Does dependent have other group coverage?
<input type="checkbox"/> Husband <input type="checkbox"/> Wife				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step-child				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step-child				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step-child				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step-child				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step-child				<input type="checkbox"/> No <input type="checkbox"/> Yes Carrier

**EMPLOYEE SIGNATURE AND CONSENT**

I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative, professional, medical, or legal services in connection with my claims or care to disclose any information necessary for investigation, evaluation, or payment of a claim. I certify that all information contained herein is true and correct.

\_\_\_\_\_  
Employee Signature                                      Date

**WAIVER OF COVERAGE – (Please complete only if waiving coverage)**

I have been offered the opportunity to participate in the EdCare Group’s medical benefits program and have chosen to waive my coverage as I have health coverage available through another group health plan. I understand that if I later apply for coverage under the Plan within 30 days of termination of such other coverage, the evidence of good health requirement will not apply and Plan coverage will commence immediately upon termination of such prior coverage.

\_\_\_\_\_  
Employee Signature                                      Date