INSURANCE APPLICATION & CHANGE FORM

EDUCATIONAL SERVICE CENTER OF NORTHEAST OHIO
6393 OAK TREE BLVD, SUITE 300
INDEPENDENCE, OH 44131

Date of Hire (Mo/Day/Yr)	Coverage Effective Date (Mo/Day/Yr)	Email Address:

Reason for Enrollment or Change

☐ New Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Waiver of Coverage
☐ Loss of Coverage ☐ Other _____ ☐ Legal Guardianship (Attached legal documentation)

Name (print) Last First Middle Initial	Social Security Number:	Date of Birth (Mo/Day/Yr)	☐ Female ☐ Male

Address: City: Zip:	Phone:	Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced

An employee's spouse is not eligible to participate in ESCNEO's medical plan if the spouse has access to coverage through their employer. This rule applies regardless of cost differences and/or network access between ESCNEO's medical plans and the plan(s) available to the spouse. This does not apply to dental or vision. It is the responsibility of all ESCEO employees to notify Human Resources within 30 days of any change of the access to medical coverage for their spouse. **If spouse does not have access to coverage elsewhere he/she is permitted to participate in ESCNEO's medical plans.**

☐ does **NOT** have access to coverage elsewhere
☐ does have access to coverage, therefore, ineligible for ESCNEO's medical coverage

CHOOSE ONE MEDICAL CARRIER:

CIGNA PPO ○ Single ○ Emp+Sp ○ Emp+Ch ○ Family ○ Waive	**CIGNA HSA** ○ Single ○ Emp+Sp ○ Emp+Ch ○ Family ○ Waive	**METRO SKYWAY** ○ Single ○ Emp+Sp ○ Emp+Ch ○ Family ○ Waive

DENTAL ○ Single ○ Emp+Sp ○ Emp+Ch ○ Family ○ Waive	**VISION** ○ Single ○ Emp+Sp ○ Emp+Ch ○ Family ○ Waive

DEPENDENTS:

Last Name	First Name	M	Social Security No.	Date of Birth	Gender

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

I authorize deductions from my earnings of the required contributions toward the cost of the coverage.

Employee Signature _____ Date _____