



**BENEFIT MANAGEMENT**  
S E R V I C E S  
P.O. Box 98044 Baton Rouge, LA 70898-9044

**St. TAMMANY PARISH  
SCHOOL BOARD**

**GROUP HEALTH BENEFITS  
ENROLLMENT FORM**

PLAN I     PLAN II

NEW     LATE     REHIRE  
 ACTIVE     RETIRED

<b>OFFICE USE ONLY</b>	SOCIAL SECURITY NO.		HEALTH ORIGINAL EFFECTIVE DATE	
		CODE	LIFE OED	LIFE CARE

**PLEASE COMPLETE THIS SECTION**

SOCIAL SECURITY NO.	LAST NAME (Print)		FIRST (Print)		MI	AC PHONE (    )		
MAILING ADDRESS		APT. #	CITY	ST.	ZIP	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER
NAME OF EMPLOYER				GROUP NO./DEPT. NO.		DATE EMPLOYED		<input type="checkbox"/> HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL
<b>DO YOU HAVE?</b>	PART A MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR PART A MEDICARE NO.	YOUR PART A EFFECTIVE DATE	MO. DAY YR.	RETIRED <input type="checkbox"/> YES <input type="checkbox"/> NO			
	PART B MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR PART B MEDICARE NO.	YOUR PART B EFFECTIVE DATE	MO. DAY YR.	ARE YOU OR ANY OF YOUR DEPENDENTS CURRENTLY RECEIVING DISABILITY/WORKERS' COMP BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	PART D MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR PART D MEDICARE NO.	YOUR PART D EFFECTIVE DATE	MO. DAY YR.				
DO YOU OR ANY DEPENDENTS HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES TO EITHER GIVE:		POLICYHOLDER	INSURANCE COMPANY			

HAVE YOU OR ANY DEPENDENT(S) BEING ADDED HAD OTHER HEALTH COVERAGE WITHIN 63 DAYS?  YES  NO

**PLEASE COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED**

GIVE FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	CHECK RELATIONSHIP, IF DEPENDENT IS OVER 21, INDICATE IF FULL TIME STUDENT				IS DEPENDENT CLAIMED ON INCOME TAX?
DOES YOUR SPOUSE HAVE PART A MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PART B <input type="checkbox"/> YES <input type="checkbox"/> NO	PART A NO.	PART B NO.	PART A EFFECTIVE DATE	MO. DAY YR.	PART B EFFECTIVE DATE	MO. DAY YR.
SPOUSE			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	FULL-TIME STUDENT	DATE DEPENDENCY BEGAN		
OLDEST CHILD			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO		% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO		% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO		% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO		% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO		% SUPPORT	<input type="checkbox"/> YES <input type="checkbox"/> NO

**FRAUD STATEMENT**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment card for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\_\_\_\_\_  
Plan Participant's Signature

\_\_\_\_\_  
Authorized Representative  
St. Tammany Parish School Board

If you are declining enrollment in your employer's group health plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

"I have read and understand the above notification. I understand that, if I decline plan coverage, I will only be able to obtain such coverage upon the plan's open enrollment period or because of one or more of the events listed above.

I am declining health coverage under the company plan due to the following reason(s)”:

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Print Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Signature **X** \_\_\_\_\_

Date: \_\_\_\_\_

**(IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE WHEN ELIGIBILITY CEASES.)**