CASEBP
DENTAL PLAN

MEMBERSHIP APPLICATION

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

PLEASE INDICATE: NEW ADDITION________ EXISTING SUBSCRIBER________ TERMINATION_______

LAST NAME | FIRST | INITIAL | SOCIAL SECURITY NUMBER

MAILING ADDRESS | C/O | COUNTY

CITY | STATE | ZIP CODE | PHONE #

SEX
__MALE __FEMALE

DATE OF BIRTH
MO DAY YR

MARITAL STATUS
__SINGLE __MARRIED

MARRIAGE DATE
MO DAY YR

NAME OF EMPLOYER
Cherry Valley-Springfield Central School

EMPLOYMENT DATE

ADDRESS OF EMPLOYER
597 Co Rd 54,
Cherry Valley, NY 13320

FEDERAL MEDICARE CLAIM NUMBER:
__MEDICARE PART A EFFEC. DATE________________
__MEDICARE PART B EFFEC. DATE________________

Check desired coverage: __INDIVIDUAL __2-PERSON __FAMILY

__HIGH-LEVEL PLAN __MID-LEVEL PLAN

LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE
PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS

LAST NAME	FIRST	DATE OF BIRTH MO DAY YR	RELATIONSHIP (HUSBAND, WIFE, SON, OR DAUGHTER)	SOCIAL SECURITY #	IS MEMBER DISABLED

On the effective date of this contract, do you or your spouse have coverage through another **MEDICAL HEALTH PLAN**?
__Yes __No **If yes**, indicate Carrier____
Name of Policyholder____
Individual Contract_____ Family Contract_____

On the effective date of this contract, do you or your spouse have coverage through another **DENTAL PLAN**?
__Yes __No **If yes**, indicate Carrier____
Name of Policyholder____
Individual Contract_____ Family Contract_____

The above information is true and correct to the best of my knowledge. If any information pertaining to this application changes, I will notify my employer immediately.

SIGNATURE____ DATE_____________________

EMPLOYER STATEMENT: Work Status: ___Full-time ___Part-time ___On Leave ___Retired (date) ________________

Date of Employment: ________________ Dental Effective Date: ________________ Termination Date: ________________

Employer Representative: ________________________________ Date: _________________ ___FSA Participant