GASD Enrollment Form

CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Drive West, Albany, NY 12205 enrollments@amsureins.com

GROUP NAME _____

Group name – Amsterdam School District

Choose Plan below:
CDPHP, MVP and Tier = Mdcr
Empire – fill out separate application, but check "other" in application box

SECTION A

Last Name First

Address

City State

☐ Separated ☐ Divorced ☐ Widowed

Date of Divorce ____/____/____

☐ Active ☐ Retired ☐ COBRA

Status Chg Date ____/____/____

SECTION B

☐ Open Enrollment (complete Section D)
☐ New Enrollment/Reinstatement (complete Section D)
☐ Change Coverage to (check new coverage)
☐ Cancel Coverage (check what applies)
☐ Add/Delete Dependent (complete section D)
☐ Information Change (complete Section A)
☐ Waive Coverage (must provide proof of Insurance)
☐ NYS Dependent Coverage up to Age 29

Reason/Comments

Indem/Blue Shield		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr
PPO/Blue Shield		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr
POS/Blue Shield		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr
CDPHP EPO					☐ Mdcr
MVP HMO					☐ Mdcr
Rx		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr
Dental		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr
Other		☐ Ind	☐ 2P	☐ Fam	☐ Mdcr

Empire listed in the "other" Box (Fill out separate application as well

SECTION C

Other Coverage?

Is there coverage under any other group health plan available to you or any of your covered dependents?

☐ Yes ☐ No

If Yes; Policyholder Name Relationship ☐ Self ☐ Spouse ☐ Child

Social Security Number ____/____/____ Birth Date ____/____/____

Insurance Co. Name Policy #

Plan Type ☐ Self only ☐ Self/Spouse ☐ Self/Child(ren) ☐ Fam

Coverage Type ☐ Health ☐ Drug ☐ Dental ☐ Vision

SECTION D

LIST APPLICABLE DEPENDENTS * (See Dependent Verification Requirement Below)

ADD	DELETE	Relationship	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date (Copy of Medicare card required)	MVP HMO & BS POS ONLY: Primary Care Physician (PCP)
☐	☐	Self ☐ M		____/____/____	n/a	____/____/____	____/____/____	
☐	☐	Spo ☐ M		____/____/____	n/a	____/____/____	____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____	
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	____/____/____	____/____/____	

SECTION E

Do your dependents reside in your home? ☐ Yes ☐ No

If No, give address: _____

Do you have a disabled dependent beyond age 19? ☐ Yes ☐ No

List name(s): _____

Full-time college students age 19 and over (Dental Only):

List Names: School Name and Address:

Dependent Verification*

School District Representative (SDR) _____ (please initial)

Date: _____

* The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).

Applicant's Signature: _____

Date: _____

Employer's Signature: _____

Date: _____

White Copy – AMSURE Yellow Copy – EMPLOYER Pink Copy – EMPLOYEE