

SECTION I - EMPLOYEE INFORMATION AND COVERAGE ELECTION

Employer Name DUBUQUE COUNTY		Group # 2202		Division	Plan
Name (First, MI, Last)			Social Security # _____	Hire Date ____/____/____	
Street Address			Telephone	Effective Date ____/____/____	
City	State	Zip	Date of Birth ____/____/____	Email address	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
		<input type="checkbox"/> Legally Separated			<input type="checkbox"/> Widow/Widower
Medical & Vision <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Decline		Reason for Completing this Form <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Marriage/Birth/Adoption <input type="checkbox"/> Terminate Coverage for one/all dependents List dependents who are no longer covered _____			<input type="checkbox"/> Part/Full-time Change <input type="checkbox"/> Special Enrollment/Loss of Coverage Date Coverage lost _____ <input type="checkbox"/> Voluntary or <input type="checkbox"/> Lost other coverage
Date of Event/Change ____/____/____					

SECTION II - ELIGIBLE DEPENDENTS INFORMATION Note: This application does not guarantee coverage.

Name (First, MI, Last)	Relationship	Social Security # -(SSN) <i>Federal law MMSEA requires collection of SSN for all dependents</i>	Date Of Birth	Gender
Spouse	<input type="checkbox"/> Spouse (lawful) <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F
Dependent	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F
Dependent	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F
Dependent	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F
Dependent	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F

SECTION III - OTHER COVERAGE Note: This section must be completed for SISCO to process your dependent claims.

PART A: Spouse (if applicable)	Date of Marriage	PART B: Ex-spouse (if applicable)	Divorce Date
Name & City of Employer Does your spouse have other coverage with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is he/she eligible for other coverage with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If your spouse does have other coverage through this employer, 1. Indicate the type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Vision 2. What date did this coverage become effective? 3. List the children covered under this plan _____		<i>(this information is for Coordination of Benefits for any dependent children)</i> Ex-Spouse Name(s) _____ Address(es) _____ Social Security # (if available) _____ Name and City of Employer(s) _____ If your ex-spouse has coverage through this employer, 1. Indicate the type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Vision 2. What date did this coverage become effective? 3. List the children covered under this plan _____	

Does your spouse or any other dependents have Medicare? Yes If yes, who? _____ No

Are your spouse or any dependents disabled? Yes If yes, who? _____ No

SECTION IV - SIGNATURE TO ELECT OR DECLINE COVERAGE

Elect: The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings (pre-tax if applicable). I authorize all providers, facilities and agencies to furnish full information pertaining to all diagnosis and treatments, this auth will be used for verification of benefit eligibility and claim processing. This consent is subject to revocation at any time through a written submission to SISCO.		Decline: I hereby certify that I have been offered an opportunity to become covered under the plan and I have decided not to take advantage of this offer. I understand that in the event I desire the coverage offered but at a later date, my application will be subject to the provisions and limitations of the Summary Plan Description.	
<input type="checkbox"/> I do have other coverage <input type="checkbox"/> I do not currently have other coverage			
Signature	Date	Signature	Date