



School Insurance Specialists

SUBSCRIBER APPLICATION

- DENTAL BENEFITS
- VISION BENEFITS

415 W. Kalamazoo St. • Lansing, MI 48933
1-800-292-5421 • Fax 517-482-4181

SCHOOL DISTRICT NAME MACOMB INTERMEDIATE SCHOOL DISTRICT	ACCOUNT # 50000
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SUBSCRIBER	SOCIAL SECURITY NO. _____	NAME (LAST) _____ (FIRST) _____ (INITIAL) _____	BIRTH DATE MO. DAY YR. _____	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
	ADDRESS - NUMBER _____ STREET _____ CITY _____ COUNTY _____ STATE _____ ZIP CODE _____					
	JOB TITLE/OCCUPATION _____	HOURS WORKED/WEEK _____	ANNUAL SALARY _____	EMPLOYMENT DATE (REQUIRED) _____	<input type="checkbox"/> NEW HIRE <input type="checkbox"/> RE-HIRE	

DEPENDENTS	NAME (FIRST) _____ LAST NAME (IF DIFFERENT) _____	SOCIAL SECURITY # _____	BIRTH DATE MO / DAY / YR _____	SEX M F	CHECK IF APPLICABLE AGE 19-25 DISABLED
	SPOUSE				<input type="checkbox"/> <input type="checkbox"/>
	CHILD				<input type="checkbox"/> <input type="checkbox"/>
	CHILD				<input type="checkbox"/> <input type="checkbox"/>
	CHILD				<input type="checkbox"/> <input type="checkbox"/>
	CHILD				<input type="checkbox"/> <input type="checkbox"/>
	CHILD				<input type="checkbox"/> <input type="checkbox"/>

PLANS	DENTAL PLAN: <input type="checkbox"/> YES <input type="checkbox"/> NO SUBGROUP # _____ <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & DEPENDENT(S)
	VISION PLAN: <input type="checkbox"/> YES <input type="checkbox"/> NO SUBGROUP # _____ <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & DEPENDENT(S)

INSURANCE INFO	ARE YOU OR ANY FAMILY MEMBER COVERED UNDER ANOTHER GROUP INSURANCE PROGRAM(S) <input type="checkbox"/> YES <input type="checkbox"/> NO — PLEASE COMPLETE BELOW			
	IF YOU HAVE NAMED A CHILD, ABOVE, WHOSE BIRTH PARENTS ARE DIVORCED OR SEPARATED, IS THERE A COURT ORDER STATING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? (PLEASE ATTACH A COPY OF THE COURT ORDER) <input type="checkbox"/> YES <input type="checkbox"/> NO WITH WHOM DOES THE CHILD RESIDE? <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER			
	NAME OF SUBSCRIBER _____	SOCIAL SECURITY NO. _____	DATE OF BIRTH _____	EMPLOYER _____
	MEDICAL NAME OF INSURANCE CO. _____	DENTAL NAME OF INSURANCE CO. _____	VISION NAME OF INSURANCE CO. _____	
EFFECTIVE DATE: _____		EFFECTIVE DATE: _____		EFFECTIVE DATE: _____

AUTHORIZATION	I CERTIFY THAT THE STATEMENTS CONTAINED HEREON ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE BENEFITS UNDER SAID GROUP PLAN ARE AVAILABLE TO INDIVIDUALS WHO ARE ACTIVELY AT WORK WITH A PARTICIPATING EMPLOYER.	
	APPLICANT SIGNATURE X	DATE