



School Insurance Specialists

# SUBSCRIBER APPLICATION

<b>SUBSCRIBER</b>	ENROLLMENT TYPE: <input type="radio"/> NEW HIRE <input type="radio"/> REHIRE <input type="radio"/> OPEN ENROLLMENT <input type="radio"/> COBRA	<i>Please print</i>			
	REASON: <input type="radio"/> MARRIAGE <input type="radio"/> LEGAL GUARDIAN <input type="radio"/> TRANSFER <input type="radio"/> LOSS OF COVERAGE	SOCIAL SECURITY NO.	NAME (LAST, FIRST, MIDDLE INITIAL)		
	DISTRICT NAME	BIRTH DATE OF EMPLOYEE (MM/DD/YY)	MARITAL STATUS	GENDER	
	ACCOUNT #	ADDRESS	CITY	STATE	ZIP CODE
	EFFECTIVE DATE	JOB TITLE/OCCUPATION	EMPLOYMENT DATE (REQUIRED)		
		HOURS WORKED/WEEK	ANNUAL SALARY		

<b>DEPENDENTS</b>	NAME: (FIRST, LAST IF DIFFERENT)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR ALL)	BIRTHDATE MM/DD/YY	OTHER INSURANCE?	CHECK IF APPLICABLE
	SPOUSE				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED

<b>GROUP PLANS</b>	MEDICAL INSURANCE PLAN: <input type="radio"/> ONE-PERSON <input type="radio"/> TWO-PERSON <input type="radio"/> FAMILY	GROUP DENTAL: <input type="radio"/> YES <input type="radio"/> NO <i>If yes,</i> <input type="radio"/> EMPLOYEE <input type="radio"/> EMPLOYEE & DEPENDENT(S)
	MEDICAL PLAN NAME/CODE	GROUP VISION: <input type="radio"/> YES <input type="radio"/> NO <i>If yes,</i> <input type="radio"/> EMPLOYEE <input type="radio"/> EMPLOYEE & DEPENDENT(S)
	HRA-WRAP: <input type="radio"/> YES <input type="radio"/> NO WAIVED MEDICAL: <input type="radio"/> YES <input type="radio"/> NO	GROUP LONG-TERM DISABILITY: <input type="radio"/> YES <input type="radio"/> NO GROUP SHORT-TERM DISABILITY (If available): <input type="radio"/> YES <input type="radio"/> NO GROUP LIFE INSURANCE: <input type="radio"/> YES <input type="radio"/> NO \$ _____ (Amount) GROUP DEPENDENT LIFE (If available): <input type="radio"/> YES <input type="radio"/> NO

**NOTE:** If choosing a Disability or Life product, please make sure to complete the "ANNUAL SALARY" line above to ensure timely processing. Your application may be delayed if incomplete.

<b>OPTIONS</b>	BASIC LIFE AND AD&D \$5,000 (Must be selected to choose other optional coverage): <input type="radio"/> YES <input type="radio"/> NO
	HOSPITAL CONFINEMENT INDEMNITY INSURANCE (Check coverage desired): <input type="radio"/> SELF ONLY <input type="radio"/> SELF & SPOUSE <input type="radio"/> SELF & CHILDREN <input type="radio"/> FAMILY \$ _____ A DAY
	SHORT-TERM DISABILITY INCOME INSURANCE: WEEKLY BENEFIT DESIRED \$ _____ BENEFITS COMMENCE ON: <input type="radio"/> 8th DAY <input type="radio"/> 29th DAY
	LONG-TERM DISABILITY INCOME INSURANCE: MONTHLY BENEFIT \$ _____
	SHORT-TERM DISABILITY/LTD COORDINATED PLAN: BENEFIT DURATION _____ WEEKLY BENEFIT _____

DEPENDENT TERM LIFE INSURANCE:  YES  NO

SURVIVOR INCOME INSURANCE (Includes surviving spouse and dependent children. Excludes sponsored dependents):  YES  NO

<b>OTHER INSURANCE</b>	Are you or any family member covered under another group insurance program(s)? <input type="radio"/> YES <i>Please complete below</i> <input type="radio"/> NO			
	Are you or any one named on this application covered by Medicare? <input type="radio"/> YES <input type="radio"/> NO			
	If you have a named 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="radio"/> YES <input type="radio"/> NO With whom does the child reside? <input type="radio"/> FATHER <input type="radio"/> MOTHER			
	NAME OF SUBSCRIBER	SOCIAL SECURITY NO.	DATE OF BIRTH	EMPLOYER
	MEDICAL INSURANCE COMPANY NAME	EFFECTIVE DATE		
	DENTAL INSURANCE COMPANY NAME	EFFECTIVE DATE		
VISION INSURANCE COMPANY NAME	EFFECTIVE DATE			

<b>BENEFICIARY</b>	PRIMARY BENEFICIARY	RELATIONSHIP	<input type="radio"/> I have read and understand the conditions on the reverse side of this form.
	SECONDARY BENEFICIARY	RELATIONSHIP	
		APPLICANT SIGNATURE	DATE

Signed form must be received within 30 days of requested effective date.

FORM NO. 021 REV. 4/19/19

Upload to [www.setseg.org](http://www.setseg.org) by logging in and choosing "Upload Employee Enrollment Forms" from the Employee Benefit Services menu, or email [enrollment@setseg.org](mailto:enrollment@setseg.org)

# SUBSCRIBER APPLICATION

**Please read the following information before completing the reverse side of this application.**

THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH SET INC. AND/OR ITS DESIGNATED UNDERWRITING INSURANCE COMPANY(IES).

I am applying for coverage under my group or association contract with SET Inc. Coverage begins on the date determined by SET Inc. and/or its underwriters. When SET Inc. accepts my application I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility:** I agree to provide proof of my dependents' eligibility for coverage when requested by SET Inc. or the appropriate insurance company(ies) underwriting my coverage(s).

**Authorization:** I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or death of someone covered under the policy. I authorize the appropriate insurance company(ies) underwriting my coverage(s) and/or my physician(s) to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage, and for other purposes necessary to fulfill the underwriter's (s') contractual and statutory obligations.

**Release of information:** SET Inc. does not require your Social Security number, however, your group or association, Medicare, Medicaid and others do require it. SET Inc. will release information about you only when:

- You authorize it in writing.
- When it must be released to process a claim (e.g. to another insurance company). Upon your written request, SET Inc. will tell you when the information was sent.

**Underwriting Insurance Companies:**

- Health Insurance
- Supplemental Medical Insurance
- Basic Life, Accidental Death and Dismemberment Insurance
- Group Medical Options
- Dental Insurance
- Vision Insurance
- Group Long-Term Disability Insurance

These benefits may be underwritten and/or administered by one or more of several Insurance Companies or Third-Party Administrators, depending on the type of coverage and carrier selected by your employer. Please contact SET Inc. or your employer regarding questions related to what specific coverage and/or carrier your employer has selected