



SUBSCRIBER APPLICATION

- DENTAL BENEFITS
- VISION BENEFITS

School Insurance Specialists

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					SCHOOL DISTRICT NAME			ACCOUNT #							
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			
	SPOUSE											AGE 19-25 <input type="checkbox"/>		DISABLED <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						