



# BAY-ARENAC ISD HEALTH PLAN – MEDICAL ONLY

New  Revised  Open Enrollment  Hire Date: \_\_\_\_\_

## Personal Information

Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

## Your Dependents

Name of Dependents	Social Security #	Birth Date	Relationship	Gender M/F

## OTHER HEALTH COVERAGE (C.O.B.)

Spouse's Employer: \_\_\_\_\_

Address of Employer : \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Name of Group Insurance Company: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date