SET SEG
School Insurance Specialists

MEC PLAN SUBSCRIBER APPLICATION

SUBSCRIBER

ENROLLMENT TYPE:

❍ NEW HIRE ❍ REHIRE ❍ OPEN ENROLLMENT ❍ COBRA

REASON:

❍ MARRIAGE ❍ LEGAL GUARDIAN ❍ TRANSFER ❍ LOSS OF COVERAGE

Please print

DISTRICT NAME

ACCOUNT #

EFFECTIVE DATE

SOCIAL SECURITY NO. | NAME (LAST, FIRST, MIDDLE INITIAL)

BIRTH DATE OF EMPLOYEE (MM/DD/YY) | MARITAL STATUS | GENDER

ADDRESS | CITY | STATE | ZIP CODE

JOB TITLE/OCCUPATION | EMPLOYMENT DATE (REQUIRED)

HOURS WORKED/WEEK

DEPENDENTS

NAME: (FIRST, LAST IF DIFFERENT)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR ALL)	BIRTHDATE MM/DD/YY	CHECK IF APPLICABLE
CHILD				❍ AGE 19-26 ❍ DISABLED
CHILD				❍ AGE 19-26 ❍ DISABLED
CHILD				❍ AGE 19-26 ❍ DISABLED
CHILD				❍ AGE 19-26 ❍ DISABLED

GROUP PLANS

MEDICAL INSURANCE PLAN:

❍ ONE-PERSON ❍ TWO-PERSON ❍ FAMILY

Or

WAIVE MEDICAL:

❍ YES ❍ NO

SIGNATURE

Herewith, I apply for participation in the employer-sponsored, minimum essential coverage health plan for myself and/or dependents. I agree to adhere to the terms and limitations of the plan as outlined by the Summary Plan Description. I attest to the accuracy and completeness of the statements made in this application, and have not omitted any material fact. I understand that this application is for participation in the employer-sponsored, minimum essential coverage plan as defined by the Patient Protection and Affordable Care Act and does not constitute major medical coverage.

APPLICANT SIGNATURE | DATE

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

REV. 5/23/16

For questions or to submit form: email enrollment@setseg.org or fax (517) 492-0872