SET SEG
School Insurance Specialists

MEC PLAN SUBSCRIBER APPLICATION

EMPLOYER

EMPLOYEE INFORMATION

NAME

SOCIAL SECURITY NUMBER

DATE OF BIRTH — GENDER ❍MALE ❍FEMALE

STREET ADDRESS

CITY — STATE — ZIP

HOME PHONE

EMAIL ADDRESS

BENEFIT SELECTION: MEC BASIC

Employee only: ❍YES ❍NO

Employee and family: ❍YES ❍NO

Total # enrolled:______________________

Waving benefits due to: ❍OTHER COVERAGE

❍OTHER REASON

REQUIRED DEPENDENT INFORMATION

NAME

SOCIAL SECURITY NUMBER

DATE OF BIRTH — GENDER ❍MALE ❍FEMALE

CHILD:
MARRIAGE AND BIRTH CIRTIFICATES ARE REQUIRED FOR ALL DEPENDENTS.

NAME

SOCIAL SECURITY NUMBER

DATE OF BIRTH — GENDER ❍MALE ❍FEMALE

CHILD:
MARRIAGE AND BIRTH CIRTIFICATES ARE REQUIRED FOR ALL DEPENDENTS.

NAME

SOCIAL SECURITY NUMBER

DATE OF BIRTH — GENDER ❍MALE ❍FEMALE

CHILD:
MARRIAGE AND BIRTH CIRTIFICATES ARE REQUIRED FOR ALL DEPENDENTS.

NAME

SOCIAL SECURITY NUMBER

DATE OF BIRTH — GENDER ❍MALE ❍FEMALE

SIGNATURE

❍I understand by signing below, I am enrolling in the benefit(s) selected or waiving health insurance coverage.

APPLICANT SIGNATURE — DATE

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

REV. 2/8/18