



NORTHERN SCHOOL DISTRICT TRUST

N.S.D.T.
 C/O CESA#12
 618 Beaser Ave
 Ashland, WI 54806
 715-682-2363
 Ext 133
 Fax 715-682-7244

Medical Enrollment

District: _____ Group #: _____
 Hire Date: _____ Effective Date of Coverage: _____

Employee	Last Name _____ First _____ M.I. _____ Date of Birth _____ Social Security# _____
	Address _____
	City _____ State _____ Zip _____ Home Phone # _____
	Gender <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married

Coverage	<input type="checkbox"/> New Hire <input type="checkbox"/> Other _____
	Medical Plan Selected: _____ <input type="checkbox"/> Single <input type="checkbox"/> Family

Spouse/Dependents	Spouse: Last Name _____ First _____ M.I. _____ Date of Birth _____ S.S.# _____					
	Dependents:					
	First Name	M.I.	Last	Date of Birth	S.S.#	Gender (M or F)
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
Do all of the dependent(s) listed above reside at the same address as the applicant? <input type="checkbox"/> Y <input type="checkbox"/> N If No, list dependent(s) name and address: _____						

Other	Do you, your spouse, or any of your dependents have any other Medical coverage? <input type="checkbox"/> Y <input type="checkbox"/> N If Yes, Please complete the Coordination of Benefits Form and send with this application.
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Waive	I have decided not to apply for the Medical Coverage Offered for: <input type="checkbox"/> Self <input type="checkbox"/> Dependents <input type="checkbox"/> Other and I understand that evidence of insurability may be requested if I desire to apply for such coverage at a later date.
	Signature _____ Date _____

Accept	I enroll for the eligible benefits I indicated in the coverage section and authorize deductions from my earnings if required.
	Signature _____ Date _____