BETHLEHEM AREA SCHOOL DISTRICT

Benefits Enrollment - COBRA

Please return to:

Benefits Office
Human Resources Department
1516 Sycamore Street
Bethlehem, PA 18017

Please print

Participant Information

Name (Last, First, MI) | Social Security Number

Mailing Address

City | State | Zip Code | Date of Birth __ __ / __ __ / __ __

Date of Retirement | Home Phone ( ) | Sex ☐ Male ☐ Female

Personal Email Address

Election

Effective Date of Coverage: / /

A. Type of Coverage

☐ Participant Single ☐ Participant + 1 ☐ Family

B. Health Plan

☐ Capital BlueCross PPO/Vision Discount Plan
☐ Express Scripts Prescription Plan ☐ Delta Dental

Covered Family Members (list all)

Relationship Codes: S=Son D=Daughter SS=Stepson SD=Stepdaughter

Name (Include Last name if different)	Sex Code M/F	Date of Birth MM/DD/YYYY	Social Security Number	Relationship Code	A – Add R - Remove NC- No Change
Spouse					
Children					

If you need more space, list additional children on a separate sheet of paper and attach to this form. Proper documentation may be required; marriage or birth certificate, social security card, etc., if not already on file.

Authorization and Acknowledgements:

I certify that I have reviewed the information of this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act (HIPAA).

Participant's Signature | Date

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