J. J. STANIS and COMPANY, INC.
100 Jericho Quadrangle · Suite 101
Jericho · New York 11753

EXCESS MAJOR MEDICAL ENROLLMENT CARD
(Please Print All Information)

Phone: (516) 465-3900
Fax: (516) 465-3920

POLICY HOLDER:_____ OCCUPATION:_____
INSURED NAME: (LAST)_____ (FIRST)_____
HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
DATE OF BIRTH:_____ SEX: ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER:_____ DATE OF EMPLOYMENT:_____
ANNUAL SALARY:_____ HOURS WORKED WEEKLY:_____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPERATED

INFORMATION FOR DEPENDENTS

Do you now have eligible dependents? ☐ Yes ☐ No If yes, are they to be included in this plan? ☐ Yes ☐ No (If yes, please list your dependents below.)

FIRST NAME	DATE OF BIRTH MO DAY YR				FIRST NAME	DATE OF BIRTH MO DAY YR			
				☐SPOUSE					☐CHILD
				☐CHILD					☐CHILD
				☐CHILD					☐CHILD

I AM APPLYING FOR ☐ INDIVIDUAL OR ☐ FAMILY COVERAGE / DATE OF MARRIAGE _____
ELIGIBILITY: In order to be eligible for Excess Medical/Rehabilitation Insurance, you must be a participant in the empire N.Y. State Government Employee Health Insurance program through either you or your spouse's employer. Check one: ☐ Own ☐ Spouse's

☐ REQUEST TO PARTICIPATE (CHECK ONE)
I hereby request the policy holder to arrange to issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions, as applicable, from my earnings as my contributions toward the cost of insurance.

Signed _____
Signature of Employee
Date _____

Reason for refusing coverage: _____
☐ WAIVER OF INSURANCE
I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required if I desire to participate in the plan at a later date.

Signed _____
Signature of Employee
Date _____

PAYROLL DEDUCTION AUTHORIZATION

Check one:
☐ Family
☐ Individual

NAME:_____**S.S. #** _____

ORGANIZATION: Hicksville Congress of Teachers

TO THE BOARD OF EDUCATION:

I hereby authorize you, according to arrangements agreed upon with the above organization, to deduct from my salary and transmit to said organization, premiums as certified for Excess Medical Coverage, by said organization. I hereby waive all right and claim to said monies so deducted and transmitted in accordance with this authorization and relieve the Board of Education and all its officers from any liability therefore. I revoke any and all instruments heretofore made by me for such purposes. This authority shall remain in full force and effect for all proposed while I am employed in the school system, or until revoked by me in writing between September 1 and September 15 of any given year.

Signature: _____ **Date**: _____