Medical Mutual Insurance Enrollment SUPPLEMENTAL APPLICATION FOR SPOUSE COVERAGE

Return form to Lake County Board of DD/Deepwood Human Resources Department

Group Name: Lake County Board of DD/Deepwood Group Number 635401
Employee is to complete sections E and F and then sign at bottom of page.

E. SPOUSE INFORMATION

SPOUSE'S FIRST NAME	M. I.	SPOUSE'S LAST NAME		
STREET ADDRESS (if different from employee)		CITY (if different)	STATE	ZIP CODE
HOME PHONE NUMBER, WITH AREA CODE		DATE SPOUSE'S INSURANCE IS EFFECTIVE		
SPOUSE'S DATE OF BIRTH (MM/DD/YY)		SPOUSE'S SOCIAL SECURITY NUMBER		
SPOUSE'S OCCUPATION		SPOUSE'S GENDER: M F		

F. OTHER MEDICAL INSURANCE COVERAGE

If you or any dependent listed on this app has other group medical insurance, please provide the following:

Name(s) of person(s) covered	Effective date of other coverage	Name of other medical insurance

G. AUTHORIZATION

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

EMPLOYEE SIGNATURE	DATE
X	

LCBDD Group Insurance Dependent Documentation Requirements
(Documentation must be attached for EACH dependent to be covered)

Your spouse will be enrolled in the same plan you chose on your application. Please return this form along with a copy of your Marriage Certificate and the appropriate notarized Spousal Affidavit.

NOTE: There is a separate application for employee-only and employee-plus-child(ren).