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 the 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 ______