

PLEASE PRINT Employee Name _____

SPOUSE ENROLLMENT INFORMATION Any request for primary coverage requires completion of Spousal Certification forms

Last Name: _____ First Name: _____ MI: _____
SSN #: _____ Birth Date: _____ Male Female
Enroll in: Health & Prescription Primary Secondary (COB info required) Vision Primary only
 Dental Primary Secondary (COB info required)

DEPENDENT CHILD ENROLLMENT INFORMATION Attach additional copies of this page to add additional dependents

If you have named a child below whose parents are divorced or legally separated, please attach a copy of Court Order.
**If seeking vision or dental coverage for a dependent age 19 or older, employee must submit dependent certification in addition to all other required information at the time of application.

Last Name: _____ First Name: _____ MI: _____
SSN #: _____ Birth Date: _____ Male Female
Relationship: _____ Address if Different: _____
Enroll in: Health & Prescription Primary Secondary (COB info required) Vision Primary only
 Dental Primary Secondary (COB info required)

I confirm this dependent meets all Plan Eligibility Rules Check box if National Medical Support Notice applies

Last Name: _____ First Name: _____ MI: _____
SSN #: _____ Birth Date: _____ Male Female
Relationship: _____ Address if Different: _____
Enroll in: Health & Prescription Primary Secondary (COB info required) Vision Primary only
 Dental Primary Secondary (COB info required)

I confirm this dependent meets all Plan Eligibility Rules Check box if National Medical Support Notice applies

Last Name: _____ First Name: _____ MI: _____
SSN #: _____ Birth Date: _____ Male Female
Relationship: _____ Address if Different: _____
Enroll in: Health & Prescription Primary Secondary (COB info required) Vision Primary only
 Dental Primary Secondary (COB info required)

I confirm this dependent meets all Plan Eligibility Rules Check box if National Medical Support Notice applies

COORDINATION OF BENEFIT INFORMATION Other Primary coverage must be in force to be eligible for secondary coverage.

Are you, your spouse, or your dependents covered by any other insurance? Yes No

Employer Name _____

Employer Address _____

Contract Holder's Name: _____ Date of Birth: _____ Relationship: _____

Attach a copy of ID card or written verification of primary coverage. Federal law prohibits a High Deductible Plan (HDP) that is partnered with a Health Savings Account (HSA) to coordinate with this Plan.

Type	Insurance Company Name	Group Policy ID	Level of Coverage	Eff. Date
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Family	_____
<input type="checkbox"/> Prescription	_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Family	_____
<input type="checkbox"/> Vision	_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Family	_____
<input type="checkbox"/> Dental	_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Family	_____
<input type="checkbox"/> Medicare	_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Family	_____

If you need additional space to list different carriers for different dependents you may attach a separate page.

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INSURANCE FRAUD WARNING:

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.

AUTHORIZATION FOR PRE-TAX INSURANCE PREMIUM AND/OR SPOUSAL PREMIUM (if applicable).

By signing this application I hereby give my authorization to have my monthly insurance premium and/or spousal premium (if applicable) deducted from my payroll check on a pre-taxed basis, through payroll deduction annually thereafter, if no new election form is filed during Open Election or based upon a Qualifying Event.

I choose **not** to elect my payroll deduction on a pre-taxed basis.

AUTHORIZATION FOR RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICE:

I hereby authorize the release of any medical records or information concerning claims, conditions or treatment of myself, and any dependents listed on the front of this form, by any provider of health services, any insurer, or other organization or person, to the Plan, its sponsor, or other representative as authorized or required by State or Federal law. Such information includes any records or knowledge about medical history contained in such records. This information will be used for purposes related to providing benefit coverage, including but not limited to: processing this enrollment/change form; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; claims reviews; peer review; health care research; public health reporting; utilization review; coordination of benefits; subrogation; and disease management/prevention. I understand that this information may also be furnished to other entities providing services on behalf of the Plan such as claims administrators, pharmacy benefit managers, insurers, re-insurers, stop loss carriers, agents, subsidiaries, and affiliates, and to governmental authorities as required or authorized by State or Federal law, or in response to a legal order. Such entities will be advised that the information must be kept confidential as required by law, and should not be used for any unlawful purpose. My signature below gives my authorization for and on behalf of myself and any of my eligible dependents enrolled for coverage under the Plan. I am acting as agent and representative of such dependents. For purposes of processing this enrollment/change form, and for all other purposes, this authorization is valid while the Plan remains in effect. A photocopy of this authorization is as valid as the original. I understand I may request a photocopy for my own records.

ACKNOWLEDGEMENT OF RESPONSIBILITY TO READ AND UNDERSTAND BENEFIT INFORMATION.

I further acknowledge that I have received a copy of the insurance booklet, and/or have access to the Wood County employee website at www.co.wood.oh.us/employee or the "office copy" of the insurance booklet and that it is my responsibility to read and understand the schedule of benefits, eligibility rules and regulations governing the Wood County Employees insurance benefits. Full details on benefits, restrictions & limitations are available in the Plan Document which is available within 30 days of request. I acknowledge that enrollment into this Plan is contingent upon complying with all Plan rules. I certify that all of the above information is true and correct to the best of my knowledge. I authorize my employer to deduct from my wages, on a pre-tax basis if elected, the required premium for the coverage for which I have applied.

SPECIAL ENROLLMENT RIGHTS:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I hereby certify that I have read and understand the above information.

Employee Signature: _____

Date: _____

If employee is not available to sign, form completed by: _____

Date: _____