WOOD COUNTY EMPLOYEE HEALTH BENEFITS PLAN UNIVERSAL INSURANCE APPLICATION
Meritain #19238 • ApproRx #99990368 • BCC- Vision -Subgroup # • Delta Dental #1395 • MetLife

☐ Initial Application/New Enrollee ☐ Contract/Information Change ☐ Employment Termination ☐ Open Election: Nov. 15- Dec. 15

PLEASE PRINT (Use names as printed on Social Security Card)

Department Name: _____ Subgroup #: _____ SSN _____

Employee Last Name: _____ First Name: _____ MI: _____

Address: _____
Street/PO Box City State Zip

Primary Phone: _____ Work Phone: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married: Date _____ ☐ Divorced: Date _____ ☐ Widowed

Birth Date: _____ Payroll Number: _____ Email Address: _____

ENROLLMENT AND/OR WAIVER OF COVERAGE (*See Special Enrollment Rights on page 3 of this application.)*

Full Time Hire Date _____ Enrollment Effective Date _____ Check if Rehired ☐

I wish to enroll in, reinstate, or waive the following: Unmarked boxes = Waiver of Coverage Prior End Date_____

Medical & Prescription	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____
Vision Coverage	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____
Dental	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____

Life Insurance Mandatory for all benefit-eligible employees. Requires completion of Wellness Screening within enrollment period.

Primary Beneficiary: _____ Relationship: _____

Secondary: _____ Relationship: _____

If no election is made, State of Ohio rules will apply. Secondary beneficiary payable only if primary is deceased.

☐ Check if you or any other family members are currently covered under the Wood County Employee Health Benefits Plan.

CONTRACT CHANGE/TERMINATION: Complete Coverage Level/Premium Change section below if coverage level changes

Date of Contract Change/Event or Termination: _____

☐ **Employee Information** List update above in Employee Information section ☐ **Life Beneficiary** List update above in Enrollment Section

☐ **Coordination of Benefit Information (COB)** Complete COB Information section with effective date of other coverage

☐ **Department Transfer** List new department above Transfer From: _____

☐ **Name** Requires copy of SS card - List new name in Employee Information section Previous Name _____

☐ **Add SS #** Include information for applicable spouse/dependent in Spouse/Dependent Enrollment Section

☐ **Add Dependent(s) Coverage** Complete Spouse/Dependent Enrollment Section(s) ☐ Marriage ☐ Birth ☐ Open Enrollment

☐ Loss of Other Coverage ☐ Newly Eligible/CHIP ☐ Other _____

☐ **Add SELECTED benefit for Subscriber/Family** Complete Initial Enrollment and Spouse/Dependent/COB Sections

Reason for ADDING ☐ Reinstate from Leave of Absence ☐ Newly Eligible ☐ Open Enrollment
☐ Late Enrollee due to Loss/Gain of Coverage ☐ Death ☐ Divorce
☐ Other _____

☐ **TERMINATION**

☐ **Terminate Dependent(s)** _____ ☐ Medical & Rx ☐ Vision ☐ Dental
_____ ☐ Medical & Rx ☐ Vision ☐ Dental

☐ Terminate **SELECTED benefit** for subscriber and family ☐ Medical & Rx ☐ Vision ☐ Dental

☐ Terminate **ALL benefits** for subscriber and family

Reason for Termination

☐ Separation of Employment ☐ Reduced Hours ☐ Leave of Absence ☐ Open Enrollment
☐ Loss of Dependent Status/Overage ☐ Military Leave ☐ Death ☐ Divorce
☐ Obtained other Group-like Coverage/Marketplace Enrollment ☐ Employee becoming eligible for Medicare
☐ Other _____

Termed Employee: Last Day of Active Pay Status _____

ACA Measurement Type at Separation See eligibility rules for coverage end date ☐ Ongoing ☐ Monthly

COVERAGE LEVEL/PREMIUM CHANGE: Note majority of changes effective 1st day of month following event

Effective Date for Coverage/Premium Change: _____

☐	**Medical & Prescription**	☐ Single to Family	☐ Family to Single	☐ No change
☐	**Vision**	☐ Single to Family	☐ Family to Single	☐ No change
☐	**Dental**	☐ Single to Family	☐ Family to Single	☐ No change

SIGNATURE REQUIRED ON LAST PAGE - Page 1

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: ☐ **Medical & 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, or requesting coverage for an overage disabled child, 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: ☐ **Medical & 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 ☐

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Last Name: _____ First Name: _____ MI:____

SSN #: _____ Birth Date: _____ ☐ Male ☐ Female

Relationship: _____ Address if Different: _____

Enroll in: ☐ **Medical & 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 ☐

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Last Name: _____ First Name: _____ MI:____

SSN #: _____ Birth Date: _____ ☐ Male ☐ Female

Relationship: _____ Address if Different: _____

Enroll in: ☐ **Medical & 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 Federal law may prohibit coordination of benefits with this Plan.

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: _____

Other Primary coverage must be in force to be eligible for secondary coverage. It is your responsibility to ensure primary plan coordinates benefits. Attach a copy of ID card or written verification of primary coverage.

Type	Insurance Company Name	Group Policy ID	Level of Coverage	Eff. Date
☐ Medical			☐ Single ☐ Family	
☐ Prescription			☐ Single ☐ Family	
☐ Vision			☐ Single ☐ Family	
☐ Dental			☐ Single ☐ Family	
☐ Medicare			☐ Single ☐ Family	

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

PLEASE PRINT Employee Name _____

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.woodcountyohio.gov 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: _____