

STATE OF OHIO
HEALTH CARE ENROLLMENT FORM
 FOR NEW ENROLLMENT AND CHANGES

SECTION I—EMPLOYEE INFORMATION

Employee ID Number	Last Name	First Name	M.I.
Address		City	State Zip Code
Home Phone	Work Phone	County of Residence	County of Work

Last Name

SECTION II—ENROLLMENT INFORMATION

Select a plan for which you are eligible: <input type="checkbox"/> Aetna HMO <input type="checkbox"/> Ohio Med PPO <input type="checkbox"/> Paramount HMO <input type="checkbox"/> The Health Plan HMO <input type="checkbox"/> UnitedHealthcare HMO	Mark all boxes that apply: <input type="checkbox"/> Elect/Change plan <input type="checkbox"/> Change dependents <input type="checkbox"/> Family to single <input type="checkbox"/> Single to Family <input type="checkbox"/> Cancel all coverage	Reason for completing form: <input type="checkbox"/> New hire <input type="checkbox"/> Transfer <input type="checkbox"/> Open enrollment <input type="checkbox"/> Plan change <input type="checkbox"/> Other
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SECTION III—FAMILY INFORMATION (List eligible dependents. Additional dependents? Obtain additional form from your agency.)

PLEASE PRINT	DOB	Sex	Social Security No.	Other Ins. (Y/N)	PCP Code
Employee					
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
<input type="checkbox"/> Child <input type="checkbox"/> Foster <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship <input type="checkbox"/> Add* <input type="checkbox"/> Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
<input type="checkbox"/> Child <input type="checkbox"/> Foster <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship <input type="checkbox"/> Add* <input type="checkbox"/> Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
<input type="checkbox"/> Child <input type="checkbox"/> Foster <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship <input type="checkbox"/> Add* <input type="checkbox"/> Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
<input type="checkbox"/> Child <input type="checkbox"/> Foster <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship <input type="checkbox"/> Add* <input type="checkbox"/> Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					

First Name

Employee ID Number

*Affidavits required for dependents age 19 to 23 and/or upon appointing as guardian/foster parent.

SECTION IV—CERTIFICATION

I hereby certify that the information entered above is true and complete and that I agree to all **Terms and Conditions** listed on the back of this enrollment form.

Employee Signature: _____ **Date:** _____

Plan Code

SECTION V—Payroll Information (to be completed by agency)

(Payroll Number)	(Payroll/Personnel Officer Signature)	(Phone No.)	(Date)	(Effective Date)	(Plan Code)
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INSTRUCTIONS FOR COMPLETING THE HEALTH CARE ENROLLMENT FORM

Use this form to select a plan for the first time, to change plans, to change coverage, or to make changes to dependent information.

Instructions

- Print clearly all the information requested in Sections I and II. Write the information about the state employee and all eligible dependents in Section III.
- Complete the information for the state employee in the first row of Section III. If required by your plan, enter the primary care physician (PCP) code for the state employee's primary care physician. You may obtain this code from the material sent to you by the health plan or by calling the plan, or by visiting its Web site.
- Complete the second row for the spouse of the state employee and the remaining rows for all other eligible dependents. List the last names of dependents only if their last name is different from the state employee. If you have more than four dependents, print additional forms. Mark the block "Other Ins" (for "other insurance") if your dependents are enrolled in another health plan. Enter the PCP code for your dependent's primary care physician, if PCP codes are required by your plan.*
- For dependents you wish to enroll for the first time, mark the box "Add." Mark the box "Child" for biological children and adopted children. Mark the box "Foster" for foster children, "Guardianship" for children of guardianship and "Stepchild" for stepchildren. Court papers must be attached for foster children and children of guardianship. Mark the box "Cancel" for any dependent for whom you wish to cancel coverage. For student dependents you wish to enroll for the first time who are 19 to 23 years of age, a notarized affidavit is required.

* All HMOs except UnitedHealthcare HMO require you to choose a primary care physician (PCP).

Terms and Conditions:

1. I have read and agree to the provisions in the Benefits Decision & Comparison Guide, the Department of Administrative Services, Benefits Administration Services Web site (www.ohio.gov/employeebenefits) and/or the summary plan descriptions for the plan year in which I am enrolling. Specifically, I have read and agree to the eligibility rules provided at www.ohio.gov/employeebenefits. My signature below certifies that all of my dependents I am enrolling for benefit coverage comply with these rules. I understand the enrolling of ineligible dependents may be considered fraud and could result in disciplinary actions up to and including but not limited to employment termination and/or reduction of retirement benefits. I also understand that I may be required to supply copies of documentation such as certified birth certificate(s), marriage certificate(s), front/last page of income tax returns and other related documentation.
2. If enrolling for coverage, which I understand is voluntary, I authorize the deduction from my paycheck for the cost of coverage, which I have elected. I understand that payment on a pre-tax basis means that my gross pay will be reduced by the cost of the coverage before any applicable taxes are deducted.
3. I acknowledge that the information on this Health Care Enrollment Form is complete and accurate. I understand that the information provided on this Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or revoke coverage.
4. If waiving health insurance coverage at this time, I understand I will have to wait to the next open enrollment period in order to enroll in any of the Plans, unless I have a qualifying family status change.
5. I cannot start, stop, or change any pretax election until the next open enrollment unless I experience a change in family status. If I experience a change in family status, I must complete a Health Care Enrollment Form within 31 days of the event and provide applicable supporting documentation of the event.
6. Any change made in anticipation of a qualifying event will not be allowed. No dependents can be added or dropped from coverage until the qualifying event has occurred.
7. I acknowledge the requirement that my and my dependent's social security numbers may be used as identifiers, as required under the Health Insurance Portability and Accountability Act (HIPAA).
8. Unless otherwise prevented by law, I authorize, for myself and my dependents, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information to the insurance provider or its authorized representatives. Furthermore, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care.