Reset Form

EmpID

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Group No.: BMI 368 **Enrollment/Change Form** **Miami County**

Check one: ☐ New Enrollment ☐ Change (attach document) ☐ Add a Dependent ☐ Termination

☐ Active Employee ☐ COBRA Participant ☐ Retiree Participant

Effective date of COBRA coverage: COBRA Termination Date:

Employee Legal Name: _____

SSN: _____

Physical* Address: _____

City, State, Zip: _____

* A physical address is only needed if you are opening an HSA; federal requirements do not allow a PO Box to be used with an HSA account.

Primary Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Date of Birth: _____ Gender: ☐ M ☐ F

Email Address: _____

Are you disabled? ☐ Yes ☐ No

Date of Hire: _____

Benefits Effective Date: _____

Date of Qualifying Event: _____

Qualifying Event: ☐ Marriage ☐ Birth ☐ Adoption

☐ Divorce/Legal Separation ☐ Loss of Dependent Status

☐ Loss of Other Coverage ☐ Other Special Enrollment

Name of Terminating Participant: _____

Reason for Termination: _____

Date of Termination: _____

This box for HR use only

MEDICAL BENEFITS

CHOOSE a medical plan: ☐ **INO 1** ☐ **INO 2**

Choice Fund - High deductible plan **with an HSA.**

Consumer Directed - High deductible plan **without an HSA.**

☐ **Choice Fund - 1500**

☐ **Consumer Directed 1**

☐ I **ELECT** Medical coverage for:
- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

☐ I **DECLINE** Medical coverage because:
- ☐ Employee is covered as dependent under another group plan
- ☐ Spouse/Children covered under another group plan
- ☐ Employee elects to be covered under Medicare
- ☐ Spouse elects to be covered under Medicare
- ☐ Other

VISION BENEFITS

☐ I **ELECT** Vision coverage for:
- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

☐ I **DECLINE** Vision coverage because:
- ☐ Employee is covered as dependent under another group vision plan
- ☐ Spouse/Children covered under another group vision plan
- ☐ Other

DENTAL BENEFITS

☐ I **ELECT** Dental coverage for:
- ☐ Employee
- ☐ Family

☐ I **DECLINE** Dental coverage because:
- ☐ Employee is covered as dependent under another group dental plan
- ☐ Spouse/Children covered under another group dental plan
- ☐ Other

ELIGIBLE DEPENDENT INFORMATION

For the following: *1) Only list eligible dependents you elect to cover on your plan (spouse and/or children/stepchildren/children of legal guardianship).*
2) Unless handicapped, a dependent child must be under the age of 26.

Dependent Name (First, MI, Last)	**Social Security #** *Dependent social security numbers are mandatory for compliance with 42 U.S.C. 1395y(b)(7).*	**Gender M/F**	**Date of Birth**	**Relationship to Employee**	**Disabled? Yes or No**

OTHER MEDICAL COVERAGE

1. Do you have other medical coverage, which is not a qualified high deductible health plan? ❑ Yes ❑ No

2. If YES, will your other coverage terminate upon this plan's effective date? ❑ Yes ❑ No

3. If you answered NO to question #2, do you understand that you may NOT be eligible for an HSA? ❑ Yes ❑ No
(see HSA eligibility requirements as you are responsible for verifying your own eligibility)

I certify that I have selected the above plan option(s) and that I fully understand the terms and conditions of the plan(s). I further certify that the above listed information is true and correct. If I knowingly elect coverage for ineligible dependents, I understand and agree the Health Plan may seek to recover all paid claims. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I understand if my employment is terminated, upon re-employment, coverage will not be effective until I again apply for benefits in accordance with the terms of the group policy.

I agree on behalf of myself and those family members enrolled ("Dependents") for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that MPR or their authorized representatives may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering health benefits, including for treatment, payment or health care operations, as those terms are explained in detail in the Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that to the extent permitted by law, health care providers, benefits providers, claims administrators, and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness and substance abuse to the Health Plan for the Plan's administration of health benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I understand that if I choose to decline coverage, I waive the right to the Health Plan's coverage until the next open enrollment, unless my dependents or I experience a Special Enrollment qualifying event.

_____ _____

Employee Signature **Date** **Print Name** **BMI 368**