WOOD COUNTY EMPLOYEES UNIVERSAL INSURANCE APPLICATION
Meritain Health #1140337 • Pharmacy Data Management Inc.#99990368 • BCC-Subgroup # • Delta Dental #1395 • MetLife

PLEASE PRINT

Department Name: _____ Subgroup #: _____ SS# _____

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

EMPLOYEE INFORMATION

Address: _____
Street/PO Box City State Zip

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

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

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

ENROLLMENT

Full Time Hire Date _____ Enrollment Effective Date _____

I wish to enroll in or reinstate:

☐	**Health & Prescription**	☐ Single	☐ Family	☐ Waive Coverage*
☐	**Vision Coverage**	☐ Single	☐ Family	☐ Waive Coverage*
☐	**Dental**	☐ Single	☐ Family	☐ Waive Coverage*

☐ **Life Insurance** Mandatory for all benefit-eligible employees.

Primary Beneficiary: _____ Relationship: _____

Secondary: _____ Relationship: _____

*See Special Enrollment Rights on page 3 of this application.

CONTRACT CHANGES

☐ **Report Change/Qualifying Event** — **Effective Date of Change** _____

Date of Event		Date of Event	
_____	Reinstate/Rehire	_____	Open Enrollment
_____	Reinstate from Leave of Absence	_____	Add SS #
_____	Termination (last date of active pay status)	_____	CHIP Eligibility
_____	Late Enrollee due to loss/gain of coverage	_____	Dependent newly eligibility
_____	Divorce/Death (circle one)	_____	Other _____

☐ **Name** Previous Name _____ New Name _____

☐ **Address** (Provide new address in Employee Information section)

☐ **Add dependent** ☐ Marriage ☐ Birth (Complete Spouse/Dependent Information Section)
☐ Loss of Coverage ☐ Other _____

☐ **Department Transfer** From: _____ To: _____

☐ **Coordination of Benefit Information** (Complete Coordination of Benefit Information Section)

If the above change or termination below results in a revised level of benefit, please select benefit type & level of coverage.

☐	**Health & Prescription**	☐ Single to Family	☐ Family to Single
☐	**Vision**	☐ Single to Family	☐ Family to Single
☐	**Dental**	☐ Single to Family	☐ Family to Single

TERMINATIONS

Effective Date of Termination _____

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

☐ **Terminate selected benefit** for subscriber and family ☐ Health & Rx ☐ Vision ☐ Dental

☐ **Terminate dependent** Name(s): _____ ☐ Health & Rx ☐ Vision ☐ Dental

_____ ☐ Health & Rx ☐ Vision ☐ Dental

☐ **Date of Event & Reason for Termination**

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

PLEASE PRINT

Dependents and/or Spouses seeking secondary coverage must provide proof of primary coverage in COB section below.

SPOUSE INFORMATION

Spouses seeking primary coverage must submit spousal certification and all other required information at the time of application.

Social Security #: _____ Last Name: _____ First Name: _____ MI:____

Birth Date: _____ ☐ Male ☐ Female Effective Date: _____

Enroll in: ☐ **Health & Prescription** ☐ Primary ☐ Secondary ☐ **Vision** ☐ Primary only
☐ **Dental** ☐ Primary ☐ Secondary

DEPENDENT CHILD INFORMATION

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

Social Security #: _____ Last Name: _____ First Name: _____MI:_____

Birth Date: _____ ☐ Male ☐ Female Effective Date: _____ Termination Date: _____

Relationship: _____ Address if Different: _____

This Dependent meets all the Plans Eligibility Rules ☐ Yes ☐ No National Medical Support Notice: ☐ Yes ☐ No

Enroll in: ☐ **Health & Prescription** ☐ Primary ☐ Secondary ☐ **Vision** ☐ Primary only
☐ **Dental** ☐ Primary ☐ Secondary

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Social Security #: _____ Last Name: _____ First Name: _____MI:_____

Birth Date: _____ ☐ Male ☐ Female Effective Date: _____ Termination Date: _____

Relationship: _____ Address if Different: _____

This Dependent meets all the Plans Eligibility Rules ☐ Yes ☐ No National Medical Support Notice: ☐ Yes ☐ No

Enroll in: ☐ **Health & Prescription** ☐ Primary ☐ Secondary ☐ **Vision** ☐ Primary only
☐ **Dental** ☐ Primary ☐ Secondary

****

Social Security #: _____ Last Name: _____ First Name: _____MI:_____

Birth Date: _____ ☐ Male ☐ Female Effective Date: _____ Termination Date: _____

Relationship: _____ Address if Different: _____

This Dependent meets all the Plans Eligibility Rules ☐ Yes ☐ No National Medical Support Notice: ☐ Yes ☐ No

Enroll in: ☐ **Health & Prescription** ☐ Primary ☐ Secondary ☐ **Vision** ☐ Primary only
☐ **Dental** ☐ Primary ☐ Secondary

COORDINATION OF BENEFIT INFORMATION – 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

Is your spouse employed? ☐ Yes ☐ No

Employer Name & Address: _____

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

Type	Insurance Company Name	Group Policy ID	Level of Coverage	Eff. Date
☐ Health			☐ 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.

Signature required on back of application to validate form.

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: _____