

STATE OF OHIO
MEDICAL BENEFIT
ENROLLMENT/CHANGE FORM FY2012

Last Name
First Name
Employee ID

SECTION I—EMPLOYEE INFORMATION					
Employee ID Number		Last Name		First Name	
Address		City		State	Zip Code
Home Phone	Work Phone		County of Residence		County of Work

SECTION II—ENROLLMENT INFORMATION		
Mark all boxes that apply: <input type="checkbox"/> Elect Plan <input type="checkbox"/> Single to Family <input type="checkbox"/> Family to Single <input type="checkbox"/> Single to Family + Spouse <input type="checkbox"/> Change Dependents <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"/> Other	

SECTION III—FAMILY INFORMATION (List eligible dependents. Additional dependents? Obtain additional form from your agency.)					
PLEASE PRINT Circle Add or Cancel to indicate the election you are making		DOB	Sex	Social Security No.	
Employee					
Spouse . Circle the action you wish to take. Add . Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
. Child . Foster . Stepchild . Guardianship . Add* . Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
. Child . Foster . Stepchild . Guardianship . Add* . Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
. Child . Foster . Stepchild . Guardianship . Add* . Cancel Name (Last, First, M.I.)					
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Address (if different from employee's):					
. Child . Foster . Stepchild . Guardianship . Add* . Cancel Name (Last, First, M.I.)					
Address (if different from employee's):					
*Affidavits required for dependents age 26 to 27 for House Bill 1 (HB1) coverage.					

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: _____

SECTION V—Payroll Information (to be completed by agency)				
_____	_____	_____	_____	_____
(Payroll Number)	(Payroll/Personnel Officer Signature)	(Phone No.)	(Date)	(Effective Date)

INSTRUCTIONS FOR COMPLETING THE MEDICAL BENEFIT ENROLLMENT FORM

Use this form to select a plan for the first time, 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.
- 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.
- 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.
- You are required to submit documentation that verifies dependent eligibility when you initially enroll or have a qualifying event. Documentation requirements can be found on the DAS website <http://das.ohio.gov/EligibilityRequirements>. The deadline for submitting your documentation is 31 days after your hire date or the date of your qualifying event. Until your dependents are verified, they will be ineligible for benefit coverage.

Terms and Conditions:

1. Medical benefit information can be accessed at www.das.ohio.gov/benefits. I have read the provisions of dependent eligibility. Specifically, I have read and agree to the dependent eligibility rules contained in the governing documents. Further, by submitting my benefit choices, I certify that the dependents under my coverage comply with these eligibility rules. Importantly, I understand that enrolling an ineligible dependent(s) may be considered fraud, and could result in disciplinary actions up to and including removal. In addition, my employer may decide to initiate court or collections action for any fraudulently paid monies.
I understand that I may be subject to an eligibility audit during any benefit year I which I am enrolled for benefits coverage. I may also be required to supply documentation such as certified birth certificate(s), marriage certificate(s), front/last page of income tax returns or other documentation related to the eligibility of my dependents. Finally, I understand that if it is found that I have fraudulently obtained benefit coverage for a dependent, I may be held financially liable by the insurance provider for the cost of any claims paid for that dependent. 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.
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 and may result in disciplinary action up to and including removal.
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 Medical Benefit 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.