ESC of the WESTERN RESERVE
Inspiring Learning Through Innovation

2020-21 Employee Benefit Enrollment / Change Form

New Enrollee Date:	**Coverage Change Date:	Open Enrollment Period Date:

Group No: HR Office Use ONLY	Section No: N/A	**Level of Benefits:**	Single Single/Spouse	Single/Child(ren) Family	Employment Status: Active

****Coverage Changes:** Date of Event: _____ New Name New Address

Add Dependents due to: Change to Medicare Eligibility

Marriage Birth Adoption Other: _____

Drop Dependents due To: Eff. Date of Change: _____

Divorce Death Other: _____

Last Name:	First Name:	MI	Email
Street Address	City	State	Zip
Phone	Employee Date of Birth	Gender Male Female	
Employee Social Security No	Marital Status: Single, Married, Widowed, Divorced, Legal Separation	Date Married	
Employer Group Name: LCSC	Date of Hire:	Job Title:	

Check Desired Healthcare Plan (only choose one); Dental; and Vision:

Medical Plan 1:	Single	Single/Sp	Single/Ch	Family					
Medical Plan 2:	Single	Single/Sp	Single/Ch	Family	**Dental:**	Single	Single/Sp	Single/Ch	Family
CDHD:	Single	Single/Sp	Single/Ch	Family	**Vision:**	Single	Single/Sp	Single/Ch	Family

Medicare Information

Are you covered by Medicare? Yes No Medicare due to:

Effective Date _____ Medicare No: _____ Hemodialysis

Is your spouse covered by Medicare? Yes No

Effective Date _____ Medicare No: _____ Hemodialysis

Other Insurance Information

Do you or any of your dependents have any other health or dental coverage? Yes No
If yes, complete section below.

Name of Policyholder	Name & Address of Insurance Company	Policy Number	Eff. Date	Coverage Types
				□ Medical □ Dental □ Vision

Work Status: Active Retired Policy Type: Single Family

What date did your most recent health insurance program become effective? (Check box if no prior/current coverage) _____ □ No Coverage

What date did/will this health insurance program terminate? (Check box if no prior/current coverage) _____ □ No Coverage

***Dependent Information Soc. Sec. No. Required**

Relationship	Birthdate	Gender	Last Name	First Name	Social Security No	Overage Dependent Status
Spouse						
Child Adopted Stepchild Other						F/Time Student Medicare Hemodialysis Disability
Child Adopted Stepchild Other						F/Time Student Medicare Hemodialysis Disability
Child Adopted Stepchild Other						F/Time Student Medicare Hemodialysis Disability
Child Adopted Stepchild Other						F/Time Student Medicare Hemodialysis Disability

Legal Documentation (court decree, guardianship papers, etc.(must be attached to this application if relationship is marked "other".

***If you are adding a dependent you MUST provide marriage certificate/birth certificate.**

Terms and Conditions

I hereby request enrollment in the coverage indicated on this enrollment form.

I authorize (1) payroll deduction(s) and remittance of any required contribution for my coverage to the plan sponsor of my group health plan; (2) these deductions to be taken on a pre-tax basis if allowable by law; (3) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), government agency or person to Medical Mutual Services (Medical Mutual): (a) to evaluate this enrollment form; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; and/or (d) for credentialing purposes. I authorize Medical Mutual and/or the sponsor of my group health plan to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of 2.5 years for the purpose of collecting information regarding this enrollment form.

My dependents and I understand and agree that any information obtained will not be released by Medical Mutual and/or sponsor of my group health plan to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any enrollment form, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. My revocation must be in writing. The revocation will not apply to information that has already been released in response to this authorization The revocation may adversely affect my enrollment or claim.

I understand and acknowledge that this authorization extends to all medical records, including records that may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV - AIDS test results or diagnosis. I expressly consent to the release of such information.

Signature

I read all of the statements contained in this enrollment form and declare by signing this enrollment form that I am an active, eligible, compensated, employee of the group and that the information that I provided is true and complete to the best of my knowledge. I understand that if allowable by law, employee contributions will be taken on a pre-tax basis and this will continue as long as I am enrolled unless I communicate to the plan sponsor, in writing, of my desire to pay my share of the cost on a post-tax basis.

Type Your Name

Employee Signature _____ Date _____

Complete the WAIVER section below only you do not want any coverage or want to waive some of the coverage options.

TO RECEIVE WAIVER PAYMENT THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY.

A. Waived coverage: I do not want (Check all that apply)

Self	Health	Drug	Dental	Vision
Dependent/s	Health	Drug	Dental	Vision

for the following dependents only:

1 _____ 2 _____ 3 _____

4 _____ 5 _____

Reason for waiving coverage: ☐ Employee/dependent has existing coverage through another group medical plan.

Must provide other ***GROUP** coverage: **Plan Name:** **Plan Group No:** **Employer Name:**

Phone No:

***only GROUP coverage eligible for in lieu of payment**

B. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver, I am choosing not to have those persons covered under the health coverage designated, and any later request for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards you or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance, or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However you must request enrollment within 60 days after such an event. In additional, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

C. If I am eligible for a cash payment due to my decision to waive coverage for myself and dependents (if applicable), I understand that I must show proof that I am enrolled in a health and prescription drug program offered by another employer which is considered a "group" plan.

I have read and understand the above terms:

Print Employee Name: _____

Print Spouse Name: _____

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.