HR/Benefits Use ONLY
Received:______________
Initials: ______________
Payroll:______________

THE BOARD OF STARK COUNTY COMMISSIONERS' HEALTH PLAN
APPLICATION, CHANGE, WAIVER FORM

☐ NEW ENROLLEE ☐ CHANGE ☐ WAIVER EFFECTIVE DATE:

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	CITY	ST	ZIP	PHONE

EMPLOYEE DATE OF BIRTH	SEX	EMPLOYEE SSN	MARITAL STATUS	DATE MARRIED
	☐ M ☐ F		☐ Single ☐ Married ☐ Widowed ☐ Divorced	

DEPARTMENT	PAYROLL FUND	EMPLOYEE ID	DATE OF FULL-TIME HIRE	JOB TITLE

ALL BENEFITS – Medical, Prescriptions (Rx), Dental, Vision	*ONLY* Dental, Vision benefits	*ONLY* Medical, Rx *benefits*
MUTUAL HEALTH SERVICES PLAN	SUPERIOR DENTAL & EYEMED	MUTUAL HEALTH & TRUE RX
◯ single ◯ family	◯ single ◯ family	◯ single ◯ family

RELATIONSHIP	BIRTH DATE MO-DAY-YR	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOCIAL SECURITY NUMBER	OVER-AGE DEPENDENT STATUS
SPOUSE		☐ M ☐ F				
☐ Child ☐ Other * ☐ Stepchild ☐ Adopted		☐ M ☐ F				☐ Handicapped/Disabled
☐ Child ☐ Other * ☐ Stepchild ☐ Adopted		☐ M ☐ F				☐ Handicapped/Disabled
☐ Child ☐ Other * ☐ Stepchild ☐ Adopted		☐ M ☐ F				☐ Handicapped/Disabled
☐ Child ☐ Other * ☐ Stepchild ☐ Adopted		☐ M ☐ F				☐ Handicapped/Disabled
☐ Child ☐ Other * ☐ Stepchild ☐ Adopted		☐ M ☐ F				☐ Handicapped/Disabled

* Legal documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked "Other".

CHANGES		DATE OF EVENT MO-DAY-YR	COV. OR CHANGE EFFECTIVE DATE MO-DAY-YR
ADD DEPENDENTS DUE TO: ☐ Marriage ☐ Birth ☐ Adoption ☐ Other DROP DEPENDENTS DUE TO: ☐ Death ☐ Divorce (attach decree) ☐ Other	☐ New Name (was ______________) ☐ New Address ☐ Change Coverage ☐ Other		

MEDICARE INFORMATION
Are you covered by Medicare? ☐ YES ☐ NO if YES, Medicare #______________ Eff. Dt. __________ ☐ Hemodialysis
Spouse covered by Medicare? ☐ YES ☐ NO if YES, Medicare #______________ Eff. Dt. __________ ☐ Hemodialysis

OTHER INSURANCE INFORMATION
Do you or any of your family members have other insurance? ☐ YES ☐ NO
If YES, name of Employer: ______________ ☐ ACTIVE ☐ RETIRED
Name of Insured: ______________
Name of Insurance Carrier: ______________ Policy No. __________ ☐ Single ☐ Family
Address: ______________

What date did your health insurance program become effective? ______________

What date did/will your health insurance program terminate? ______________

TERMS AND CONDITIONS
Your signature on this form will indicate your understanding that your employer will enroll you for all group plan coverage for which you are eligible, and will constitute your authorization to your employer or any of its agents to release to the Plan's administrators, carriers, or health care coverage organizations, as applicable, the information contained on this form. Each dependent listed on this form must be an eligible dependent in accordance with your group health care plan. Your signature on this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare-approved organization or provider of services to release any information necessary to process a claim. Your signature also authorizes payroll deduction of required contributions for the benefits you have elected.

Signature: Date:

WAIVER
I hereby waive coverage in the above health plan programs for: ☐ MYSELF ☐ MYSELF AND FAMILY MEMBERS

☐ FAMILY MEMBERS ONLY ☐ ONLY THE FOLLOWING ______________________________

I understand that if I decide to enroll or add family members at a later date, I must wait until the next Open Enrollment period, unless I and/or my eligible family members meet the Plan's Special Enrollment requirements.

Signature: Date:

INSURANCE FRAUD WARNING: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.' (OHIO REVISED CODE SECTION 3999.21)