WAYNE COUNTY DEPENDENT/HEALTH FORM

A. TYPE OF CHANGE: **THIS FORM IS MANDATORY FOR ALL NEW HIRES (*for electronic version see your payroll dept.)***

☐ New/Open Enrollment– Effective Date: _____ ☐ Waive Coverage ☐ Non-Eligible/Dependent Information

☐ Termination/Retirement– Last Day Worked:_____ ☐ Loss of Insurance Eligibility– Date:_____

☐ Birth/Adoption of Child– Date:_____ ☐ Married/ Divorced– Date:_____ ☐ Death– Date: _____

☐ Address Change-Date: _____ ☐ Other-Date: _____Explanation:_____

B. EMPLOYEE INFORMATION:

Employee #:	Last Name:	First Name:	MI:	Social Security #	Birthdate:

Mailing Address:	City:	State:	Zip Code:	County:

Personal Contact Phone #:	Work Phone #:	Department:	Hire Date:

Marital Status:	Gender:	E-mail Address:
☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Male ☐ Female	

C. PRODUCT SELECTION (only complete if enrolling or waiving County Insurance)

Option 1: **Health First PPO**	Option 2: **HDHP Consumer Driven**	Option 1: **Traditional Dental**	Option 2: **Orthodontic Dental**
☐ Single	☐ Single	☐ Single	☐ Single
☐ Family	☐ Family	☐ Family	☐ Family

Option 3: **Waive Health Insurance For:**		**Waive Dental Insurance For:**	
☐ Employee	☐ Spouse	☐ Employee	☐ Spouse
☐ Dependents	☐ Entire Family	☐ Dependents	☐ Entire Family

By waiving coverage at this time ,understand that you, and your dependents will not be eligible to obtain health insurance until open enrollment occurs or you have a qualifying event.

D. OTHER MEDICAL COVERAGE INFORMATION: (only complete if enrolling in County Insurance)

Have you or anyone listed on this application had Medical Coverage in the last 12 months? ☐ Yes ☐ No

If so, who and what is their relationship to you? _____

Will this other coverage be terminated? ☐ Yes ☐ No Date:_____ Effective Date of this coverage:_____

Name of Insurance Company:_____

Policy Holder's Name, Date of Birth & Social Security Number: _____

Type of Coverage: _____

Is this coverage through your Spouses Employer? ☐ Yes ☐ No If yes, Employer's Name:_____

E. MEDICARE COVERAGE: (only complete if enrolling in County Insurance)

Effective dates of Parts A _____ B_____ Medicare Claim # _____

Reason for Medicare Eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled

F. FAMILY INFORMATION: (this page must be completed by <u>all</u> employees)

☐ I do not have a spouse ☐ I have no children (under the age of 26)

1. Spouse ☐ No coverage requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Marriage Certificate if adding spouse to our insurance.

2. ☐ Child ☐ Disabled ☐ No coverage requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Birth Certificate if adding child to our insurance.

3. ☐ Child ☐ Disabled ☐ No Coverage Requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Birth Certificate if adding child to our insurance.

4. ☐ Child ☐ Disabled ☐ No coverage requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Birth Certificate if adding child to our insurance.

5. ☐ Child ☐ Disabled ☐ No coverage requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Birth Certificate if adding child to our insurance.

6. ☐ Child ☐ Disabled ☐ No coverage requested ☐ Add ☐ Delete ☐ Male ☐ Female Age:

Last Name	First Name	MI	Birthdate	Social Security #

Please provide copy of Birth Certificate if adding child to our insurance.

G. TERMS AND CONDITIONS:

TERMS AND CONDITIONS

In consideration of the approval and acceptance of my Application for health care benefits through the Wayne County Employee Benefit Plan, I agree to the following terms and conditions:

1. I authorize pre-tax deductions from my wages, if necessary, for the required premium for the coverage for which I have applied on my behalf, and on behalf of my dependent(s), if any. I also understand that not all contributions for health insurance may be taken out pre-tax if they are not eligible.
2. I understand that to the extent permitted by law, the Wayne County Employee Benefit Plan reserves the right to accept or decline this Application and that no right whatsoever is created by this Application.
3. I understand that I am responsible to notify the Benefits Administrator within 30 days of any change that would make me or any dependent eligible or ineligible for coverage.
4. I understand that if I give false information, or fail to update information, in order to obtain insurance benefits that Wayne County Employee Benefit Plan (Plan) will either reverse the processing of ineligible claims, or that I will be responsible for the repayment to the Plan for the entire cost of any ineligible claims paid by the Plan,for myself and any family members, and any applicable penalties allowable under law.
5. I understand that if I wish to cancel this Application for benefits in the Wayne County Employee Benefit Plan because of a qualifying event, I will provide written notice to the Benefit Administrator within 72 hours of signing this application.
6. I understand that telephone conversations between me and agents for our current Benefit Plan Vendors may be monitored and recorded; I agree and consent to the recording and/or monitoring of any telephone conversation between me and our Benefit Plan Vendors.
7. I understand that any misstatements or failure to report new information prior to the effective date may result in a material charge to coverage or premium rates.
8. Any material misrepresentation or significant omission found in this Application may result in denial of benefits or rescission or cancellation of my coverage(s).
9. I have received a copy of the "Notice of Privacy Practices" for Wayne County Employee Benefit Plan
10. I understand that if another party is responsible for payment of any of the claims paid by the Plan, then the Plan has subrogation rights to recover its costs. I agree to cooperate with the Plan to help recover those funds.
11. I understand that 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.
12. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Wayne County Employee Benefit Plan. I am acting as their agent and representative.

I have read these Terms and Conditions, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this Application are true and accurate to the best of my knowledge and I acknowledge that they are being relied on by the Wayne County Employee Benefit Plan in accepting this Application.

Please read these Terms and Conditions carefully before signing. Review your Application for errors and omissions. By signing this, you are indicating that you have read and understand the language in the Terms and Conditions of this Application and agree to all of its terms.

☐ This form is for employee/dependent information only. I affirm that the information contained in on this form is true, accurate and complete, to the best of my knowledge.

Employee Signature Date

H. TO BE COMPLETED BY AUDITOR AND COMMISSIONER'S OFFICES:

Date Received	Auditor's Office	Policy #	Group #	Subgroup#	Effective or Termination Date	Dept #