WAYNE COUNTY HEALTH INSURANCE ADD/CHANGE FORM

A. EMPLOYEE INFORMATION:

Hire /Full Time Status date: _____

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

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

Personal Phone Number:	Gender:	Marital Status:	Department:
	☐ Male ☐ Female	☐ Single ☐ Married	

B. TYPE OF CHANGE:

EFFECTIVE DATE OF CHANGE: _____ (CHECK APPROPRIATE BOX BELOW) *All qualifying events require a "Qualifying Event Form"*

ADD INSURANCE

- ☐ New Employee
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Loss of Insurance
- ☐ Open Enrollment
- ☐ Other: (explain) _____

REMOVE INSURANCE

- ☐ Resignation/Termination
- ☐ Retirement
- ☐ Divorce
- ☐ Loss of Insurance
- ☐ Open Enrollment
- ☐ Dependent turning 26

OTHER

- ☐ Waive Coverage
- ☐ Name Change
- ☐ Address Change
- ☐ Other: _____

C. PRODUCT SELECTION

Option 1: **Medical PPO**
- ☐ Single
- ☐ Family

Option 2: **Medical High Deductible**
- ☐ Single
- ☐ Family

Option 1: **Traditional Dental**
- ☐ Single
- ☐ Family

Option 2: **Orthodontic Dental**
- ☐ Single
- ☐ Family

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

Waive Dental Insurance For:
- ☐ Employee
- ☐ Dependents
- ☐ Spouse
- ☐ 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:

Do you or any of the dependents you are requesting coverage for currently have health insurance? ☐ Yes ☐ No

If no, skip to section E.

If yes:

List the names of those covered: _____

Coverage is through: ☐ Spouse Employer ☐ Medicare ☐ Medicaid ☐ Other: _____

Please list insurance company name: _____

Will the coverage be terminated? ☐ Yes ☐ No If yes, please state date of termination: _____

E. FAMILY INFORMATION:

*** A marriage certificate is required if adding a spouse; a birth certificate is required if adding children.**

1. Spouse ☐ Add ☐ Delete		☐ Male ☐ Female		Age:
Last Name	First Name	MI	Birthdate	Social Security #
2. Child ☐ Disabled ☐ Add ☐ Delete		☐ Male ☐ Female		Age:
Last Name	First Name	MI	Birthdate	Social Security #
3. Child ☐ Disabled ☐ Add ☐ Delete		☐ Male ☐ Female		Age:
Last Name	First Name	MI	Birthdate	Social Security #
4. Child ☐ Disabled ☐ Add ☐ Delete		☐ Male ☐ Female		Age:
Last Name	First Name	MI	Birthdate	Social Security #
5. Child ☐ Disabled ☐ Add ☐ Delete		☐ Male Female ☐		Age:
Last Name	First Name	MI	Birthdate	Social Security #

F. 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 tele-phone 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.

_____

Employee Signature Date

_____

Employee's personal email address

G. TO BE COMPLETED BY AUDITOR :

Date Received	Auditor's Office	Effective or Termination Date	Dept #