

# Lucas County Health Benefits 2016 Enrollment/Change Form

**Section I - Employee Information and Instructions**

Employee ID \_\_\_\_\_ Department ID \_\_\_\_\_  
Department Name \_\_\_\_\_

Please mark all (  ) appropriate boxes and circle appropriate responses

EFFECTIVE DATE \_\_\_\_\_

New Hire

Addition of Spouse or Dependent

Change Name or Address

Transfer

Name: \_\_\_\_\_

Change PCP

From: \_\_\_\_\_

Drop Spouse or Dependent

Drop Coverage

To: \_\_\_\_\_

Name: \_\_\_\_\_

Is your spouse a Lucas County employee?

Change Other Health Care Information

Yes  No

Last Name	First Name	M. I.	Birth Date	Social Security Number
Street Address	City	State	Zip	Phone (H) _____ Phone (W) _____
Male /Female	Marital Status (Single, Married, Divorced, Legally Separated, Widowed.)		Date Of Marital Status	Tobacco Use Yes No

Website: You may access detailed information on all health, drug, dental, and life plans offered to Lucas County employees and their dependents at <http://www.co.lucas.oh.us/index.aspx?nid=235> (Lucas County Employee Benefits/Wellness Link).

Section One (I) (above) is for your personal data. You must complete every field in this section.

Section Two (II) is for your spouse's personal information and coordination of benefits information. Please complete all applicable fields and attach all necessary documentation.

Section Three (III) is for your dependents' personal information and coordination of benefits information. Please complete all applicable fields. If you need additional dependent forms, simply make the necessary amount of copies from the blank form you have been provided in this packet.

Section Four (IV) is your benefit enrollment choices for plan year 2016. Please check only one selection for each health, drug, dental, and life plan you wish to enroll in. All selections you make are binding until the next open enrollment period.

After you have reviewed the forms, please sign and date on the spaces provided and return the forms, **ALONG WITH ANY NECESSARY DOCUMENTATION**, to your department benefits representative **no later than 31 days from the date of event**.

If you have any questions regarding how to complete the forms, eligibility or documentation requirements, etc. please contact your department benefit representative.

Signature: _____	Date: _____
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**INSURANCE FRAUD WARNING:**

Any person, who, with intent to defraud or knowing that he / she is facilitating a fraud against a benefits plan, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

## Social Security Identification Number Consent

\_\_\_\_\_, understand that reasonable use of my social security number is a fundamental imperative to correct administration of these plans and the delivery of proper medical care. I hereby authorize Lucas County to use my social security identification number to assist in benefits administration. I am not authorizing indiscriminate, unlimited or unwarranted access to my social security identification number. I hereby authorize the county to only release this number to any entity directly responsible for benefits administration or medical services delivery. If you refuse the use of your social security identification number as stated above, a separate form must be completed in order to enroll in the health plans.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section II - Spouse**

(Circle one) - Add / Drop / Change / No Change

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_ Dept ID: \_\_\_\_\_

Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Marriage \_\_\_\_\_  
Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Male / Female \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Tobacco Use: Yes No  
Effective Date of Add / Drop / Change \_\_\_\_\_

Effective March 1, 2014 spouses are no longer eligible for primary health insurance coverage through Lucas County. Spouses will be eligible for secondary coverage provided they are enrolled as primary in a qualified health plan with a minimum coverage of 60/40. Spouses must comply with the network provisions of the plan they are enrolled in as primary and secondary. (Please note: Spouses enrolled primary with Medicare, Medicaid, Tricare, VA, or any other government sponsored plan, are not eligible for secondary health coverage with Lucas County). Spouses will remain eligible for primary prescription drug and dental coverage pursuant to the Lucas County spousal eligibility rules.

**Medical**

If you are enrolling in the Paramount HMO, please designate a PCP and PCP ID# for your spouse. HMO PCP \_\_\_\_\_ PCP ID# \_\_\_\_\_

**Spouse's Other Medical Coverage Information**

Effective Date of Coverage \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_

**Dental**

None

**Spouse's Other Dental Coverage Information**

Effective Date of Coverage \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_

**Prescription Drug**

None

**Spouse's Other Prescription Drug Coverage Information**

Effective Date of Coverage \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_

### Section III - Dependent

(Circle one) - Add / Drop / Change / No Change

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_ Dept ID: \_\_\_\_\_

Dependent Name \_\_\_\_\_ Relationship \_\_\_\_\_  
SSN \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ Full Time Student Yes No  
City, State, Zip \_\_\_\_\_ Tobacco Use: Yes No  
Is this a college address? Yes No Permanently Physically Disabled/Mentally Disabled Yes No  
Male/Female \_\_\_\_\_ Effective Date of Add / Drop / Change \_\_\_\_\_

Court Order (circle one)  
Yes / No  
Responsible Person:  
\_\_\_\_\_

**Yes No**

- Is your dependent covered on any other insurance plan? If yes, complete 'Other Coverage' sections below.
- Is your dependent employed? If yes, employer's name and phone # \_\_\_\_\_
- If yes, is your dependent ELIGIBLE for any health/drug insurance through their employer?
- If yes, is your dependent enrolled in their employers health/drug insurance? (if yes, please fill out the form below.)

#### Medical

If you are enrolling in the Paramount HMO, please designate a PCP and PCP ID# for your dependent.

None

HMO PCP \_\_\_\_\_ PCP ID# \_\_\_\_\_

#### Dependent's Other Medical Coverage Information

Effective Date of Coverage \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Policy Number \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_

#### Dental

None

#### Dependent's Other Dental Coverage Information

Effective Date of Coverage \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Policy Number \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_

#### Prescription Drug

None

#### Dependent's Other Prescription Drug Coverage Information

Effective Date of Coverage \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Policy Number \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_

# Benefit Enrollment Selections

For 2016 Program Year (3/1/16 - 2/28/17)

## Section IV

Employee Name: \_\_\_\_\_ Employee ID \_\_\_\_\_ Department ID \_\_\_\_\_

Below are your medical, dental, prescription drug and life insurance options. The plan year is effective March 1, 2016 through February 28, 2017. After you have made your enrollment selections, please make a copy for your personal records and return the original to your department benefits representative, along with any required documentation (if applicable), no later than 31 days from the date of the event. If you enroll in Paramount HMO, you must designate a Paramount Primary Care Physician (PCP) for each member enrolled. Lucas County cannot guarantee the participation of any medical, prescription drug or dental provider under any of the medical, prescription drug, or dental plans it offers. Your selections will be effective for the remainder of the plan year.

### Medical Choose only **one** option:

Lucas County Plan through FrontPath:  Single  Family

Lucas County Plan through HealthSpan:  Single  Family

Paramount HMO:  Single  Family

Waive Coverage:

Employee PCP Section & PCP ID # \_\_\_\_\_

### Dental Choose only **one** option

Lucas County Traditional Dental Plan  Single  Family

Corner Dental Plan  Single  Family

Superior Dental PPO Plan  Single  Family

Waive Coverage

### Prescription Drug Choose only **one** option

Lucas County Drug Plan  Single  Family

Waive Coverage

Life Insurance Choose only **one** option  Enroll  Waive

On behalf of myself and my eligible dependents, I understand that all selections I have made above are binding until the end of the plan year. If I experience a qualifying event, I must complete, sign, and return a new enrollment form to my department representative within 31 days of that qualifying event. I also understand that by applying for any Lucas County Health, Drug, Dental or Life Insurance Plan option described above, I agree to comply with the coverage provisions of the applicable Plan Documents/Group Service Agreements, copies of which are available through the Lucas County Employee Benefits website. I authorize the plan(s), or its designated claims administrator, to coordinate benefits and/or reimbursement with other health or insurance companies in accordance with the Plan Documents. I further authorize any medical provider, insurance company or any other organization to release to the plan(s), or its designated claims administrator, copies of records concerning examinations, treatments, history, diagnosis, prescription or other medical information relating to medical expenses incurred. I understand that such information and records will be used by the plan(s), or its designated claims administrator, for the purpose of evaluating and administering claims for benefits. The Plan, or its designated claims administrator, may release such records for those purposes, or for the purpose of coordinating benefit payment under any Non-Duplication of Benefits Provisions to its representatives performing business or legal functions. I know that I have the right to ask for and receive a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original. I certify that all information is true and correct to the best of my knowledge. I understand that by enrolling in any of these plans offered, unauthorized services performed by any non-network provider will be considered out of network. Paramount is a covered Entity under HIPAA, and is permitted to use, obtain and disclose Member Protected Health Information (PHI) to perform Paramount operations in accordance with Paramount's Notice of Privacy Practices. Under the Paramount HMO, I agree to choose a participating Paramount physician for primary care

Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against a benefits plan, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I certify that all the above information is correct.

Signature Required \_\_\_\_\_ Date \_\_\_\_\_