GROUP BENEFITS ENROLLMENT FORM

EMPLOYER/ORGANIZATION	MASTER GROUP #	LOCATION #
Delaware County Government	**2925**	

LAST NAME OF EMPLOYEE MEMBER	M.I.	FIRST NAME

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY # OF EMPLOYEE	SEX	DATE OF BIRTH	MARITAL STATUS	DATE OF HIRE
	☐ Male ☐ Female		☐ Single ☐ Married	

PHONE NUMBER	JOB TITLE OR POSITION	EFFECTIVE DATE OF COVERAGE

TYPE OF COVERAGE REQUESTED	INDIVIDUALS TO BE COVERED
☐ MEDICAL / RX / DENTAL / VISION	☐ EMPLOYEE ONLY ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + SPOUSE ☐ FAMILY

INFORMATION FOR FAMILY MEMBERS TO BE COVERED

NAME	RELATIONSHIP	SOC SEC NUMBER	DATE OF BIRTH	SEX
SPOUSE				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female
DEPENDENT				☐ Male ☐ Female

OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health Insurance including Medicare? ☐ Yes ☐ No

If YES: Name of Insured Person:	Covered Dependents:

Employed By:	Social Security #:

Insurance Company Name / Medicare:	Medical Policy#:

EMPLOYEE'S CERTIFICATION FOR COVERAGE:

1. I hereby request the amount(s) and form(s) of coverage for which I am eligible under the plans(s) of my employer/organization and I authorize the same to deduct the required contribution, if any, from my earnings/funds. I reserve the right to revoke this authorization at any time upon written notice.

2. I hereby certify that the dependents listed are my dependents as defined in the benefit plan. I agree to notify the plan administrator of any change in status of my dependent or of any additional dependents I may acquire.

3. I hereby authorize my physician to release medical information to Unified Group Services, Inc. and/or the utilization review program arranged by my employer/organization. I understand I could be penalized for non-participation if I do not inform the utilization review nurse of a hospitalization or service requiring precertification as defined in the benefit plan for myself or for a covered dependent. (Applies only if employee participates in utilization review program.)

DATE COMPLETED

SIGN YOUR NAME HERE - DO NOT TYPE OR PRINT

CREDITABLE COVERAGE

The term "Creditable Coverage" generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental, and church plans) that are not followed by a period of more than sixty-three (63) days without coverage (not including any applicable waiting period), and Creditable Coverage generally excludes periods of coverage for liability, limited scope dental or vision benefits, specific disease and/or other supplemental-type benefits.

You may obtain proof of Creditable Coverage from your previous plan. If you have questions about obtaining Creditable Coverage, please call Unified Group Services, Inc. at 1-800-291-5837.

DECLINATION OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Notwithstanding the above, if an employee or employee's dependent Medicaid or CHIP coverage is terminated as a result of loss of eligibility, such employee or dependent has 60 days to request enrollment in this Plan. Further, if an employee or dependent becomes eligible for premium assistance subsidy under Medicaid or CHIP, the employee or dependent has 60 days to request enrollment in this Plan.

I understand that the individuals listed below will not be eligible for coverage until such time one of the following occurs:

1) Loss of other health care insurance not provided by your employer/organization;
2) Loss of eligibility for coverage as a result of legal separation, divorce, or death;
3) Reduction of hours of employment (no longer in eligible class);
4) Termination of contributions by employer toward other coverage;
5) CHIP coverage is terminated as a result of loss of eligibility;
6) Eligibility for premium assistance subsidy under Medicaid or CHIP commences; or
7) Until next applicable enrollment period.

DECLINATION OF COVERAGE

I am declining coverage at this time for the following individuals:

NAME	DATE OF BIRTH	RELATIONSHIP	REASON FOR DECLINATION

By signing below I am verifying that I understand the declination above and agree to its terms.

DATE COMPLETED

SIGN YOUR NAME HERE - DO NOT TYPE OR PRINT