OTTAWA COUNTY EMPLOYEE HEALTH PROGRAM

Employee Application / Change Form

BASIC INFORMATION

GROUP NO.	LEVEL OF BENEFITS: WAIVE COVERAGE (Complete back page) ☐
844879	☐ **PPO**: ☐Single ☐ Employee & Children ☐Employee & Spouse ☐ Family ☐ **HSA**: ☐Single ☐ Employee & Children ☐Employee & Spouse ☐ Family

Employee ID No.:	Employee Section No.:
Date of Event: Mth Day Year / /	Coverage or Change Eff. Date Mth Day Year / /

Changes:

☐ New Name ☐New Address ☐ Change Coverage ☐ Other _____

Add Dependents due to: ☐ Marriage * ☐Birth ☐Adoption ☐ Other _____

Drop Dependents due to: ☐ Divorce ☐ Death ☐ Other _____

*If adding spouse – must complete the spouse form indicating health coverage through employer

Last Name	First Name	M

Street Address	City	Ohio	Zip	Phone No.

Employee DOB Mth Day Year / /	Sex ☐ M ☐ F	Employee SSN: - -	Marital Status: ☐ Single ☐ Married ☐Widowed ☐ Divorced ☐Legal Separation	Date Married Mth Day Year / /

Department Name:	Date of Hire – Full Time Mth Day Year / /	Job Title:

Other Insurance Information

OTHER INSURANCE INFORMATION

Do you or any of your dependents have any other health or dental coverage? ☐ YES ☐ NO

If yes, complete the section below.

Name of Policy Holder	Insurance Co. Name/Address.	Policy No.	Eff. Date	Coverage Types	Work Status	Policy Type
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Presc. Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Presc. Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective? _____/ _____/_____

Check box if no prior/current coverage. ☐ No Coverage

What date did/will this health insurance program terminate? _____/ _____/_____

Check box if no prior/current coverage. ☐ No Coverage

DEPENDENT INFORMATION

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

DEPENDENT INFORMATION

Relationship	Birthdate Mth Day Yr.	Sex		Last Name (only if different)	First Name	Soc. Sec. No.	Explain Over Age Dependent Status
☐ Spouse	/ /	☐ M ☐ F					
☐ Child ☐ Step Child ☐ Adopted ☐ *Other	/ /	☐ M ☐ F					
☐ Child ☐ Step Child ☐ Adopted ☐ *Other	/ /	☐ M ☐ F					
☐ Child ☐ Step Child ☐ Adopted ☐ *Other	/ /	☐ M ☐ F					
☐ Child ☐ Step Child ☐ Adopted ☐ *Other	/ /	☐ M ☐ F					

TERMS AND CONDITIONS

I hereby apply for the coverage indicated on the Application.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual, and/or any affiliates or division of Medical Mutual, and/or the sponsor of my group health plan; (2) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), prescription history database supplier, pharmacy benefit manager, government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; and/or (d) for credentialing purposes. I authorize Medical Mutual and/or other sponsor of my group health plan to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

My dependents and I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care operations, payment related, or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Medical Mutual's Privacy Office. The revocation will not apply to information that has already been released in response to the authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. Your refusal to authorize the release of this information may impact your ability to enroll in Medical Mutual's health plan if Medical Mutual needs this information to determine your eligibility for coverage.

I understand and acknowledge that this authorization extends to all medical records, including records that may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that Medical Mutual and/or plan sponsor, may rescind my policy on the basis of any material misrepresentation or fraudulent responses to any questions. I further agree that if a policy is issued, it will be issued by Medical Mutual in full reliance and in consideration of the information, answers and statements contained herein.

I have read the materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefit comparison summary or other description of the plan.

A permanent ID card will be issued following the final review and acceptance of this Application.

SIGNATURE

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I agree that to be eligible for coverage I must be a full-time employee as defined by the policy and I must be actively at work. If I am not actively at work on the date coverage would begin my coverage will begin on the day I return to work.

_____ _____

Employee Signature Date

Note: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against a 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)

WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY IF YOU DO NOT WANT ANY COVERAGE

A. Waived coverage: I do not want coverage for (Check all that apply)

☐ Self ☐ Dependent (s)

1. _____ 2. _____ 3. _____ 4. _____

Please indicate reason for waiving coverage:

☐ Covered by spouse or parent's employer coverage
Name of Insurer:_____

☐ Medicare ☐ TRICARE ☐ VA Coverage ☐ Medicaid

☐ Individual – My policy was obtained through an exchange and I was approved for a subsidy
Name of Insurer:_____

☐ Enrolled in another carrier's group plan offered by this employer
Name of Insurer:_____

☐ Enrolled in another employer's group plan as an employee or retiree
Name of Insurer:_____

☐ Other: _____

B. Terms and Declarations:

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependents other coverage ends (or after the employer stops contributing toward other coverage). If you or your dependent becomes eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I have read and understand the above items:

Current Employer: _____

Employee Name: _____
PRINT

Employee Signature: _____ Date: _____

WARNING: If you or your family members are covered by more than one healthcare plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.