

Lake Erie Regional Council

# 1885 Lake Avenue, Elyria, Ohio 44035 Phone: 440-324-5777 Fax: 440-324-4485

***INSURANCE ENROLLMENT FORM***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYEE INFORMATION** | | | | | | | | | | | | | |
| **FULL NAME** | |  | | | | | | | | | **BIRTH DATE** | |  |
| **ADDRESS**  **CITY, ZIP CODE** | |  | | | | | | | | | **PHONE** | |  |
| **SOCIAL SECURITY** | |  | | | | | | | | | **SEX** | |  |
| **MARRIED \_\_\_\_\_\_\_\_\_\_\_ MARRIAGE DATE:\_\_\_\_\_\_\_\_\_\_\_\_ SINGLE\_\_\_\_\_\_\_\_\_\_ DIVORCED\_\_\_\_\_\_\_\_\_\_\_ WIDOWED\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| **COVERAGE INFORMATION**  **ALL NEW ENROLLEES ARE ENROLLED IN THE WELLNESS PLAN** | | | | | |  | **TO BE COMPLETED BY DISTRICT OFFICE** | | | | | | |
| **PLAN** | | | **SINGLE** | | **FAMILY** | **DECLINE** | **SCHOOLDISTRICT** | | **AMHERST LOCAL SCHOOLS** | | | | |
| **SUPERMED PLUS PREMIUM** | | |  | |  |  | **DATE OF HIRE** | |  | | | | |
|  | | |  | |  |  | **EFFECTIVE DATE** | |  | | | | |
| **MINIMUM VALUE PLAN** | | |  | |  |  | **DEPARTMENT** | | **ADMINISTRATIVE**  **CERTIFIED**  **CLASSIFIED** | | | | |
| **I would like to cover the following dependents:** | | | | | | | | | | | | | |
| **DEPENDENT** | **LAST NAME** | | | **FIRST NAME** | | | | **DOB** | | **SEX** | | **SS#** | |
| **Spouse** |  | | |  | | | |  | |  | |  | |
| **Dependent** |  | | |  | | | |  | |  | |  | |
| **Dependent** |  | | |  | | | |  | |  | |  | |
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| **Dependent** |  | | |  | | | |  | |  | |  | |
| **Dependent** |  | | |  | | | |  | |  | |  | |

Are you or any dependent on **Medicare**? YES\_\_\_\_\_\_\_ NO\_\_\_\_

Medicare Policyholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you and/or your spouse are on Medicare but have coverage through LERC, your group health plan is primary and Medicare is secondary.**

**EMPLOYEE SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By signing I agree that I received a HIPAA Notice of Special Enrollment Rights Statement**

**TREASURER/DESIGNEE SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please review your HIPAA Notice of Special Enrollment Rights on page two.**

**HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within “30 days'' or any longer period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within “30 days'' or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.