



LAKE ERIE REGIONAL COUNCIL

1885 Lake Avenue, Elyria, Ohio 44035

440-324-5777 Fax: 440-324-4485

INSURANCE ENROLLMENT FORM

FIRST NAME		LAST NAME		BIRTH DATE		SEX	
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STREET ADDRESS		CITY		ZIP CODE	
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SOCIAL SECURITY NO		DATE OF HIRE		EFFECTIVE DATE OF COVERAGE	
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STATUS	SINGLE		MARRIED		MARRIAGE DATE		DIVORCED		WIDOWED		PHONE	
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DISTRICT IN WHICH YOU WORK	AMHERST Please return completed form to the Treasurer's Office											
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Please click on appropriate boxes below:

MEDICAL PLANS	SINGLE	FAMILY	DECLINE	ADMINISTRATIVE EMPLOYEE	CERTIFIED EMPLOYEE	CLASSIFIED EMPLOYEE
PREMIUM						
MINIMUM VALUE PLAN						

DEPENDENT	LAST NAME	FIRST NAME	DOB	SEX	SS#	MED	DEN
SPOUSE							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

DOES SPOUSE WORK FOR A LERC SCHOOL DISTRICT? IF YES PLEASE CLICK ON DISTRICT BUTTON:						
AMHERST	CLEARVIEW	COLUMBIA	LORAIN COUNTY EDUCATIONAL SERVICE CTR	FIRELANDS	LCJVS	
KEYSTONE	LORAIN CITY	MIDVIEW	SHEFFIELD/SHEFFIELD LAKE	VERMILION	WELLINGTON	

Are you or any dependent on Medicare? Yes No	MEDICARE POLICYHOLDER	
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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	
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By signing I agree that I received a HIPAA Notice of Special Enrollment Rights Statement. Please review your HIPAA Notice of Special Enrollment Rights.

TREASURER/DESIGNEE SIGNATURE		DATE	
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By entering your name electronically on this form you are agreeing that your electronic signature is the legal equivalent of your manual signature (Board Policy 6107). Please note that birth certificates, marriage certificates and Social Security Cards should be kept on file. When necessary, a copy may be requested. Thank you.



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OTHER INSURANCE COVERAGE

Complete this form EVEN if your spouse/dependents have no other coverage including other LERC Plans.

FIRST NAME		LAST NAME		SOCIAL SECURITY	
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CLAIMS WILL **NOT** BE PAID IF YOU DO NOT **CONFIRM** OR **DENY** OTHER INSURANCE FOR YOUR DEPENDENTS

My dependents have other coverage:	YES		NO	
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OTHER CARRIER INFORMATION	
INSURANCE CARRIER	
EMPLOYER	
NAME OF INSURED	
POLICY NUMBER	
EFFECTIVE DATE	
CANCELLED DATE	

LIST INDIVIDUALS COVERED UNDER THE OTHER PLAN AND SELECT PLAN COVERAGE (Medical/Dental/Vision/Prescription)

DEPENDENT	LAST NAME (if different)	FIRST NAME	MED/RX	DENTAL	VISION	INSURANCE PROVIDER NAME
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

EMPLOYEE SIGNATURE		DATE	
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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.