Medical and Dental Insurance Enrollment / Change Form

Please print and thank you for providing this information.

Amherst Exempted Village Schools
Records & Benefits
185 Forest Street
Amherst, Ohio 44001
440-988-8846 440-988-3700

A

☐ New Employee
☐ Open Enrollment
☐ Change

Type of Change: * List names in Section C

☐ Add Dependent (s)*: ☐ Marriage ☐ Birth ☐ Adoption
☐ Cancel Dependent (s)*: ☐ Divorce ☐ Death ☐ Other _______
☐ Cancel Employee ☐ Retirement
☐ Address Change ☐ Transfer to Cobra
☐ Other ____________ ____________

B

Employee Name *(Last)*	*(First)*	*(M.I.)*	Social Security No.
			| | | | | | | |

Employee Date of Birth	Home Phone	Work Phone	Home eMail Address	Medical: Single / Family	Dental: Single / Family	Effective Date of Add / Change / Cancellation:
/ /	( )	( )		☐ ☐	☐ ☐	____/_____/ 20______

Address *(Street)*	*City*	*State*	*Zip*

C

I would like coverage for the following: Last Name *(specify if different from yours)* First Name M.I.	Dependent Social Security No.	Date of Birth *MM DD YYYY*	Gender	Full Time Student *Yes No*	Coverage Selection	If you chose CIGNA Dental HMO, enter your Dental Office Number	Existing Patient? *Yes No*
Employee		/ /	☐ Male ☐ Female		☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐
Spouse		/ /	☐ Male ☐ Female		☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐
*Dependent** *Relationship*		/ /	☐ Male ☐ Female	☐ ☐	☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐
*Dependent** *Relationship*		/ /	☐ Male ☐ Female	☐ ☐	☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐
*Dependent** *Relationship*		/ /	☐ Male ☐ Female	☐ ☐	☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐
*Dependent** *Relationship*		/ /	☐ Male ☐ Female	☐ ☐	☐ Medical ☐ Dental PPO ☐ Dental HMO		☐ ☐

*Dependents - Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental coverage. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

D

Other Health Care Coverage:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

Name of Person Covered	Social Security No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
			☐	☐	☐	☐
			☐	☐	☐	☐

E

Signature - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Employee's Signature / Date	Spouse's Signature / Date	Employer's Signature / Date

Life Insurance Enrollment / Change Form

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G **Life and AD&D Insurance** Please indicate your beneficiary below.

Beneficiary Name *(Last)* *(First)* *(M.I.)*	*Primary*	*Secondary*	*Relationship*	*% of Insurance*
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Provisions

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other part who has primary responsibility for service provided by the healthplan, I will immediately reimburse the healthplan to the extent of the services provided, to the extent permitted by state law.

Fraud Warning

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Authorization to Deduct Contributions

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

H **Signature** - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on this form which I have read and understand.

Employee's Signature / Date	Spouse's Signature / Date	Employer's Signature / Date