St. Lawrence County Health and Life Insurance **New ___ Qualifying Event Change___ Open Enrollment ___**

ENROLLMENT FORM

Employee/Enrollee Information:

Name (Last, First, MI)	Social Security No.	Phone	Sex	Birth Date	Marital Status
			Male ☐ Female ☐		Single ☐ Married ☐ Separated ☐ Legal, Separated ☐ Divorced ☐

Address (Street No., City, State, Zip Code)	County	Enrolled in Medicare?	Other Insurance?
		Yes ☐ No ☐	Yes ☐ No ☐

List eligible dependents to be covered in order of age (including spouse)

Spouse Information:

Name (Last, First, MI)	Birth Date	Social Security No.	Disabled?	Enrolled in Medicare?	Other Insurance? [Verified]
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Is your spouse employed? Yes ☐ No ☐

Dependent Information:

Name (Last, First, MI)	Relationship	Birth Date	Sex M/F	Social Security No.	Disabled?	Enrolled in Medicare?	Other Insurance? [Verified]
					Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

STOP : If you answered yes to any of the above questions you MUST complete the Coordination of Benefits section of this form (page 2).

I hereby certify that I have been given an opportunity to enroll for Group Health and Life Insurance benefits as offered by my employer, and after careful consideration,

I elect the following coverage:

Health Insurance Coverage				Life Insurance Coverage		
Waived ☐	Individual ☐	Employee with Dependents ☐	Family ☐	Waived ☐	Individual ☐	Dependent ☐

I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, PHYSICIAN, SURGEON OR PHARMACY TO RELEASE INFORMATION REQUESTED BY ST. LAWRENCE COUNTY OR IT'S REPRESENTATIVES TO PROCESS CLAIMS INVOLVING ME OR MY FAMILY. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO ANY DOCTOR, PHYSICIAN OR OTHER PROVIDER FOR SERVICES WHICH HE/SHE MAY RENDER TO ME OR MY FAMILY. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I DESIRE TO PARTICIPATE IN THE GROUP MEDICAL AND/OR LIFE PROGRAM AND AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTIONS FROM MY WAGE OR SALARY TO PAY MY PART OF THE COST.

_____

SIGNATURE OF EMPLOYEE DATE

OFFICE USE ONLY: Health Insurance Coverage Code _____ Life Insurance Coverage Code _____

Approved by _____ Effective Date _____ Employee's Name _____

COORDINATION OF BENEFITS INFORMATION

THE FOLLOWING MUST BE COMPLETED IF YOU OR ANY OTHER FAMILY MEMBER HAS ANOTHER GROUP HEALTH INSURANCE.

Your contract contains a COORDINATION OF BENEFITS (C.O.B.) clause which restricts payment of duplication of benefits when a person is covered under another Group Health Insurance through an employer. Are you or any family member(s) listed on enrollment form covered by **another** Group Health Insurance or Medicare?

YES ☐ NO ☐ **IF YES, COMPLETE QUESTIONS BELOW.**

Full name of person carrying Group Health Insurance _____ Date of Birth _____

Relationship to our subscriber _____ Contract Holders Employee Status: Active ☐ Retired ☐ Effective Date _____

Type of Coverage: Single Insured ☐ **and** Spouse only ☐ Children only ☐ Family ☐

Full name and complete address of other Employer:

Name _____ Phone No. _____

Address _____

Full name and complete address of other Insurance Carrier(s) for

Hospital/Comprehensive _____ Effective Date _____

Medical _____ Effective Date _____

Major Medical _____ Effective Date _____

Rx Drugs _____ Effective Date _____

Policy No. _____ SS No./Medicare # _____ Medicare: Part A ☐ Part B ☐ Effective _____

If dependent child of separated or divorced parents are covered on either contract, Name of Parent with Custody _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR THE COUNTY OF ST. LAWRENCE OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT , WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I certify that all the above information is true and complete.

_____

Signature of employee/enrollee Date Phone number

Definition of a Qualifying Event:

- A change in legal marital status, as through marriage or divorce.
- A change in the number of the employee's dependents, as through birth, adoption or death.
- A change in employment status—but only if it alters eligibility or contribution amounts.
- Satisfaction of, or failure to satisfy, requirements for being considered a dependent.
- A change in residence if it affects eligibility for a plan such as a health maintenance organization.
- Commencement or termination of adoption proceedings.
- HIPAA special enrollment events
- Judgment, decree or court order, such as a Qualified Medical Child Support Order (QMCSO)
- Medicare or Medicaid entitlement