

Lucas County Health Benefits 2012 Open Enrollment Forms

Section I - Employee Information and Instructions

Employee ID _____ Department ID _____
Department Name _____

Please mark all () appropriate boxes and circle appropriate responses

EFFECTIVE DATE _____

Open Enrollment

Addition of Spouse or Dependent

Change Name or Address

Transfer

Name: _____

Change PCP

From: _____

Drop Spouse or Dependent

Drop Coverage

To: _____

Name: _____

Is your spouse a Lucas County employee?

Change Other Health Care Information

Yes No

Last Name	First Name	M. I.	Birth Date	Social Security Number
Street Address	City	State	Zip	Phone (H) _____ Phone (W) _____
Male /Female	Marital Status (Single, Married, Divorced, Legally Separated, Widowed.)		Date Of Marital Status	Tobacco Use Yes No

Website: You may access detailed information on all health, drug, dental, and life plans offered to Lucas County employees and their dependents at <http://www.co.lucas.oh.us/index.aspx?nid=235> (Lucas County Employee Benefits/Wellness Link).

Section One (I) (above) is for your personal data. You must complete every field in this section.

Section Two (II) is for your spouse's personal information and coordination of benefits information. Please complete all applicable fields and attach all necessary documentation.

Section Three (III) is for your dependents' personal information and coordination of benefits information. Please complete all applicable fields. If you need additional dependent forms, simply make the necessary amount of copies from the blank form you have been provided in this packet.

Section Four (IV) is your benefit enrollment choices for plan year 2012. Please check only one selection for each health, drug, dental, and life plan you wish to enroll in. All selections you make are binding until the next open enrollment period.

After you have reviewed the forms, please sign and date on the spaces provided and return the forms, **ALONG WITH ANY NECESSARY DOCUMENTATION**, to your department benefit rep. **no later than February 3, 2012.**

If you have any questions regarding how to complete the forms, eligibility or documentation requirements, etc. please contact your department benefit representative.

Signature: _____	Date: _____
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INSURANCE FRAUD WARNING:

Any person, who, with intent to defraud or knowing that he / she is facilitating a fraud against a **benefits plan**, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Social Security Identification Number Consent

_____, understand that reasonable use of my social security number is a fundamental imperative to correct administration of these plans and the delivery of proper medical care. I hereby authorize Lucas County to use my social security identification number to assist in benefits administration. I am not authorizing indiscriminate, unlimited or unwarranted access to my social security identification number. I hereby authorize the county to only release this number to any entity directly responsible for benefits administration or medical services delivery. If you refuse the use of your social security identification number as stated above, a separate form must be completed in order to enroll in the health plans.

Signature: _____ Date: _____

Section II - Spouse

(Circle one) - Add / Drop / Change

Employee Name: _____ Employee ID: _____ Dept ID: _____

Spouse Name _____ SSN _____ Date of Marriage _____
Address _____ Birth Date _____ Male / Female _____
City, State, Zip _____ Tobacco Use: Yes No
Effective Date of Add / Drop / Change _____

- Yes No Must be completed if married!
- Is your spouse employed? If yes, employers name and phone #: _____
- Is your spouse ELIGIBLE for any health/drug insurance through their current employer /retirement plan / Medicare / or Social Security Plan?
- If yes, is your spouse enrolled in any other health/drug insurance? (If yes, please fill out form below.)
- Did your spouse accept cash or any other incentive to NOT enroll in their employer's health/drug insurance?
- Is your spouse required to pay 40% or more of their employees' premium for the lowest cost single health plan?
- Is your annual gross household earnings \$75,000 or less? (A separate form is required to apply for a hardship appeal)
- Is your annual gross household earnings more than \$75,000?

Medical

If you are enrolling in the Paramount HMO, please designate a PCP and PCP ID# for your spouse. HMO PCP _____ PCP ID# _____

Spouse's Other Medical Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____
Policy Holder Name _____ Policy Holder Employer Name _____
Policy Number _____ Policy Holder Employer Addr _____
Policy Holder Date of Birth _____ City, State, Zip _____
Relationship to Policy Holder _____ Phone Number _____

Dental

Spouse's Other Dental Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____
Policy Holder Name _____ Policy Holder Employer Name _____
Policy Number _____ Policy Holder Employer Addr _____
Policy Holder Date of Birth _____ City, State, Zip _____
Relationship to Policy Holder _____ Phone Number _____

Prescription Drugs

Spouse's Other Prescription Drug Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____
Policy Holder Name _____ Policy Holder Employer Name _____
Policy Number _____ Policy Holder Employer Addr _____
Policy Holder Date of Birth _____ City, State, Zip _____
Relationship to Policy Holder _____ Phone Number _____

Section III - Dependent

(Circle one) - Add / Drop / Change

Employee Name: _____ Employee ID: _____ Dept ID: _____

Dependent Name _____ Relationship _____
SSN _____ Birth Date _____
Address _____ Full Time Student Yes No
City, State, Zip _____ Tobacco Use: Yes No
Is this a college address Yes No Permanently Physically Disabled/Mentally Disabled Yes No
Male/Female _____ Effective Date of Add / Drop / Change _____

Court Order (circle one)
Yes / No
Responsible Person:

- Yes No
- Is your dependent covered on any other insurance plan? If yes, complete 'Other Coverage' sections below.
 - Is your dependent employed? If yes, employer's name and phone # _____
 - If yes, is your dependent ELIGIBLE for any health/drug insurance through their employer?
 - If yes, is your dependent enrolled in their employers health/drug insurance? (if yes, please fill out the form below.)
 - Did your dependent accept cash or any other incentive to NOT enroll in their employer's health/drug insurance?

Medical

If you are enrolling in the Paramount HMO, please designate a PCP and PCP ID# for your dependent. HMO PCP _____ PCP ID# _____

Dependent's Other Medical Coverage Information

Effective Date of Coverage _____	Insurance Company Name _____
Policy Holder Name _____	Policy Holder Employer Name _____
Policy Number _____	Policy Holder Employer Addr _____
Policy Holder Date of Birth _____	City, State, Zip _____
Relationship to Policy Holder _____	Phone Number _____

Dental

Dependent's Other Dental Coverage Information

Effective Date of Coverage _____	Insurance Company Name _____
Policy Holder Name _____	Policy Holder Employer Name _____
Policy Number _____	Policy Holder Employer Addr _____
Policy Holder Date of Birth _____	City, State, Zip _____
Relationship to Policy Holder _____	Phone Number _____

Prescription Drugs

Dependent's Other Prescription Drug Coverage Information

Effective Date of Coverage _____	Insurance Company Name _____
Policy Holder Name _____	Policy Holder Employer Name _____
Policy Number _____	Policy Holder Employer Addr _____
Policy Holder Date of Birth _____	City, State, Zip _____
Relationship to Policy Holder _____	Phone Number _____

Benefit Enrollment Selections

For 2012 Program Year (3/1/12 - 2/28/13)

Section IV

Employee Name: _____ Employee ID _____ Department ID _____

Below are your medical, dental, prescription drug and life insurance options. The plan year is effective March 1, 2012 through February 28, 2013. After you have made your enrollment selections, please make a copy for your personal records and return the original to your department benefits representative, along with any required documentation (if applicable), no later than February 3, 2012.

If you enroll in Paramount HMO, you must designate a Paramount Primary Care Physician (PCP) for each member enrolled. Lucas County cannot guarantee the participation of any medical, prescription drug or dental provider under any of the medical, prescription drug, or dental plans it offers. Your selections will be effective for the remainder of the plan year.

Medical Choose only **one** option:

- | | | | |
|--|---|---|---|
| Lucas County Health Plan through FrontPath: | <input type="checkbox"/> Single | Lucas County Plan through HealthSpan: (Formerly Physicians Health Collaborative) | <input type="checkbox"/> Single |
| | <input type="checkbox"/> Family | | <input type="checkbox"/> Family |
| | <input type="checkbox"/> Family w/ Spouse Primary #1
(2010 Gross Annual Household Income \$75,000 or Less) | | <input type="checkbox"/> Family w/ Spouse Primary #1
(2010 Gross Annual Household Income \$75,000 or Less) |
| | <input type="checkbox"/> Family w/ Spouse Primary #2
(2010 Gross Annual Household Income above \$75,000) | | <input type="checkbox"/> Family w/ Spouse Primary #2
(2010 Gross Annual Household Income above \$75,000) |
| Paramount HMO: | <input type="checkbox"/> Single | Waive Coverage: | <input type="checkbox"/> |
| | <input type="checkbox"/> Family | | |
| | <input type="checkbox"/> Family w/ Spouse Primary #1 (2010 Gross Annual Household Income \$75,000 or Less) | | |
| | <input type="checkbox"/> Family w/ Spouse Primary #2 (2010 Gross Annual Household Income above \$75,000) | | |
| | Employee PCP Section & PCP ID # _____ | | |

Dental Choose only **one** option

- | | | |
|--------------------------------------|---------------------------------|---------------------------------|
| Lucas County Traditional Dental Plan | <input type="checkbox"/> Single | <input type="checkbox"/> Family |
| Corner Dental Plan | <input type="checkbox"/> Single | <input type="checkbox"/> Family |
| Ameritas Dental PPO Plan | <input type="checkbox"/> Single | <input type="checkbox"/> Family |
| Waive Coverage | <input type="checkbox"/> | |

Prescription Drug Choose only **one** option

- | | | |
|------------------------|---------------------------------|---------------------------------|
| Lucas County Drug Plan | <input type="checkbox"/> Single | <input type="checkbox"/> Family |
| Waive Coverage | <input type="checkbox"/> | |

Life Insurance Choose only **one** option

- Enroll Waive

On behalf of myself and my eligible dependents, I understand that all selections I have made above are binding until the end of the plan year. If I experience a qualifying event, I must complete, sign, and return a new enrollment form to my department representative within 31 days of that qualifying event. I also understand that by applying for any Lucas County Health, Drug, Dental or Life Insurance Plan option described above, I agree to comply with the coverage provisions of the applicable Plan Documents/Group Service Agreements, and the Lucas County Employee Benefits Eligibility Rules, copies of which are available through the Lucas County Employee Benefits website. I authorize the plan(s), or its designated claims administrator, to coordinate benefits and/or reimbursement with other health or insurance companies in accordance with the Plan Document and the Lucas County Eligibility Rules. I further authorize any medical provider, insurance company or any other organization to release to the plan(s), or its designated claims administrator, copies of records concerning examinations, treatments, history, diagnosis, prescription or other medical information relating to medical expenses incurred. I understand that such information and records will be used by the plan(s), or its designated claims administrator, for the purpose of evaluating and administering claims for benefits. The Plan, or its designated claims administrator, may release such records for those purposes, or for the purpose of coordinating benefit payment under any Non-Duplication of Benefits Provisions to its representatives performing business or legal functions. I know that I have the right to ask for and receive a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original. I certify that all information is true and correct to the best of my knowledge. I understand if I enroll in the Dental PPO Plan or Corner Dental Plan that unauthorized services performed by any non-network provider will be considered out of network. Paramount is a covered Entity under HIPAA, and is permitted to use, obtain and disclose Member Protected Health Information (PHI) to perform Paramount operations in accordance with Paramount's Notice of Privacy Practices. Under the Paramount HMO, I agree to choose a participating Paramount physician for primary care. If appropriate, I authorize Lucas County to deduct pre-tax from my wages, the amount required (if any) to cover any contribution or co-pay for coverage under the plan(s).

Any person, who, with intent to defraud or knowing that he / she is facilitating a fraud against a benefits plan, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I certify that all the above information is correct.

Signature Required _____ Date _____