



BGSU HealthCare Enrollment and Change Form

BGSU

MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

(PLEASE USE BALL POINT PEN)

| | | | | | | | |
|---|--|---|--|---|----------------|---|---|
| BASIC INFORMATION | ENROLLEE: <input type="checkbox"/> CHANGE | | <input type="checkbox"/> NEW ENROLLEE | | GROUP # _____ | | |
| | COVERAGE LEVEL: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> Waived | | | | | | |
| | CHANGES: <input type="checkbox"/> Add Dependents due to: <input type="checkbox"/> New Name <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> New Address <input type="checkbox"/> Drop Dependents Due To: <input type="checkbox"/> Change to Medicare Elig. <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ <input type="checkbox"/> Change Coverage | | | | | | |
| | | | | DATE OF EVENT MO. ____ DAY ____ YR. ____ | | COV. OR CHANGE EFF. DATE MO. ____ DAY ____ YR. ____ | |
| | Last Name | | First Name | | M Initial | | |
| | Address / P.O. Box | | City | | State Zip+ | | |
| | Employee Date of Birth MO. ____ DAY ____ YR. ____ | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced | | | Date Married MO. ____ DAY ____ YR. ____ |
| | BGSU ID # | Employee Social Security Number | | Date of Hire-Full Time MO. ____ DAY ____ YR. ____ | | Admin <input type="checkbox"/> Faculty <input type="checkbox"/> Classified <input type="checkbox"/> | |
| | MEDICARE INFORMATION | Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis Is your spouse covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Medicare No. _____ Effective Date: _____ <input type="checkbox"/> Hemodialysis | | | | | |
| | - If electing Single coverage or waiving coverage drop down to Signature/Waiver Section. - If electing Two Person or Family coverage complete dependent information below. Once complete drop down to Signature section. | | | | | | |
| QUESTIONS | Complete Only if Covering Spouse | | | | | | |
| | Is your spouse employed? <input type="checkbox"/> YES <input type="checkbox"/> NO Full time____ Part-time____ Self-Employed____ If your spouse is employed, does his/her employer offer health care benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | Spouse's Name of Employer _____ | |
| OTHER INSURANCE INFORMATION | DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE SECTION BELOW. | | | | | | |
| | NAME OF POLICY HOLDER | NAME AND ADDRESS OF OTHER INSURANCE COMPANY | | POLICY NUMBER | EFFECTIVE DATE | COVERAGE TYPES | |
| | | | | | / / | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug | |
| | | | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Retired | |
| What date did your most recent health insurance program become effective (check box if no prior/current coverage)? ____/____/____ <input type="checkbox"/> No coverage What date did/will this health insurance program terminate (check box if no prior/current coverage)? ____/____/____ | | | | | | | |
| DEPENDENT INFORMATION | RELATIONSHIP | BIRTHDATE MO. DAY YR. | SEX | LAST NAME (ONLY IF DIFFERENT) | FIRST NAME | SOC. SEC. NO. | |
| | Spouse* | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | |
| | <input type="checkbox"/> Child* <input type="checkbox"/> Adopted* | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability <input type="checkbox"/> Student If student list school |
| | <input type="checkbox"/> Stepchild* | | | | | | |
| | <input type="checkbox"/> Other* | | | | | | |
| | <input type="checkbox"/> Child* <input type="checkbox"/> Adopted* | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability <input type="checkbox"/> Student If student list school |
| | <input type="checkbox"/> Stepchild* | | | | | | |
| <input type="checkbox"/> Other* | | | | | | | |
| <input type="checkbox"/> Child* <input type="checkbox"/> Adopted* | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability <input type="checkbox"/> Student If student list school | |
| <input type="checkbox"/> Stepchild* | | | | | | | |
| <input type="checkbox"/> Other* | | | | | | | |
| <input type="checkbox"/> Child* <input type="checkbox"/> Adopted* | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Disabled Medicare Elig.; <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Disability <input type="checkbox"/> Student If student list school | |
| <input type="checkbox"/> Stepchild* | | | | | | | |
| <input type="checkbox"/> Other* | | | | | | | |
| * Legal Documentation (court decree, legal guardianship or custodial papers, etc.) must be attached to this application if not already on file. | | | | | | | |
| SIGNATURE | I certify the above completed information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may result in termination of my benefits and may subject me to legal action by MM and BGSU. I authorize BGSU to deduct from my pay any required contribution for said coverage. In order for MM to apply appropriate benefits to treatment and services provided to me/and or my dependent, I consent to any medical professional, hospital, clinic, or other medical or medically related facility, government agency or other provider of care to provide MM information including copies of medical records (if needed) concerning care or treatment, information relating to mental illness or use of drugs or alcohol. I understand that this health care coverage I am enrolling in contains coordination of benefits, workers' compensation and subrogation provisions and I acknowledge MM's right on behalf of BGSU to enforce these provisions. Any employee who receives money from the Health Care Plan to which he or she is not entitled will be required to fully reimburse the Plan. I also understand that I must notify BGSU within 31 days of occurrence of any changes in status. | | | | | | |
| | Applicant's Signature _____ | | | | | | Date: _____ |
| WAIVER | I hereby waive coverage under the health insurance program <input type="checkbox"/> FOR MYSELF <input type="checkbox"/> FOR MYSELF AND FAMILY MEMBERS I understand that if I decide to enroll or add family members at a later date, I may be required to meet certain medical underwriting requirements before coverage will be offered. | | | | | | |
| | Signature _____ | | | | | | Date: _____ |
| *For all employees as of January 1, 2006: If you are electing to cover your spouse and he/she is employed, you must complete and return the Working Spouse Form with this Enrollment form before coverage will commence. | | | | | | | |

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)