MEDICAL MUTUAL OF OHIO
Your healthcare partner since 1934

BGSU HealthCare Enrollment and Change Form

(PLEASE USE BALL POINT PEN)

BGSU

ENROLLEE: ☐ CHANGE ☐ NEW ENROLLEE GROUP #_____

PLAN ELECTION: ☐ Plan A ☐ Plan B

COVERAGE LEVEL: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Waived

CHANGES: ☐ Add Dependents due to:
☐ Marriage ☐ Birth ☐ Adoption
☐ Drop Dependents Due To:
☐ Divorce ☐ Death ☐ Other _____
☐ New Name
☐ New Address
☐ Change to Medicare Elig.
☐ Change Coverage

DATE OF EVENT MO. ___ DAY ___ YR. ___

COV. OR CHANGE EFF. DATE MO. ___ DAY ___ YR. ___

BASIC INFORMATION

Last Name | First Name | M Initial

Address / P.O. Box | City | State | Zip+

Employee Date of Birth MO. DAY YR. | Sex ☐ M ☐ F | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced | Date Married MO. DAY YR.

BGSU ID # | Employee Social Security Number | Date of Hire-Full Time MO. DAY YR. | Admin ☐ Faculty ☐ Classified ☐

MEDICARE INFORMATION

Are you covered by Medicare?
☐ YES ☐ NO If YES, Medicare No. _____ Effective Date: _____ ☐ Hemodialysis Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. _____ Effective Date: _____ ☐ 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? ☐ YES ☐ NO Full time_____ Part-time____ Self-Employed_____
If your spouse is employed, does his/her employer offer health care benefits? ☐ YES ☐ NO
Spouse's Name of Employer_____

OTHER INSURANCE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ YES ☐ NO IF YES, COMPLETE THE SECTION BELOW.

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐Medical ☐Dental ☐Hospital Only ☐Vision ☐Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)?____/____/____ ☐ 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.	OVER AGE DEPENDENT STATUS
Spouse*		☐ M ☐ F				
☐ Child[1] ☐ Adopted[1] ☐ Stepchild[1] ☐ Other[1]		☐ M ☐ F				☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability ☐ Student If student list school
☐ Child[1] ☐ Adopted[1] ☐ Stepchild[1] ☐ Other[1]		☐ M ☐ F				☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability ☐ Student If student list school
☐ Child[1] ☐ Adopted[1] ☐ Stepchild[1] ☐ Other[1]		☐ M ☐ F				☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability ☐ Student If student list school
☐ Child[1] ☐ Adopted[1] ☐ Stepchild[1] ☐ Other[1]		☐ M ☐ F				☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability ☐ Student If student list school
☐ Child[1] ☐ Adopted[1] ☐ Stepchild[1] ☐ Other[1]		☐ M ☐ F				☐ Disabled Medicare Elig.; ☐ Hemodialysis ☐ Disability ☐ Student If student list school

[1] 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 ☐ FOR MYSELF ☐ 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)