Benefit Enrollment/Change/Cancellation Form for UHC, Delta, and VSP

Employer Section: Columbus State Community College			**Hire Date:**
	Group Number	**Group Plan**	
UHC	708223	☐ Core PPO Plan_____	☐ HDHP/HSA Plan
Delta	0007414	☐Dental	
VSP Plan	30008366	☐ Vision	
Health Effective/Change Date		Dental Effective/Change Date	Vision Effective/Change Date

Employee Complete Sections 1 - 8

1. Reason for Change				
Choose Qualifying Event	Event date: / /			
a☐ Newhire	☐ Annual open enrollment	☐ Rehire (date) / /	☐ COBRA	☐Special enrollment / Life event (complete section 2)

2. Special enrollment/Life event		**3. Type of Coverage / Plan**		
☐ Marriage	☐Status Change PT/FT	***Health Coverage - UHC***	***Dental Coverage - Delta***	***Vision Coverage - VSP***
☐Court Order	☐Partner/Spouse's open enrollment	☐**Core Plan** ☐ HDHP/HSA Plan ☐ EE only ☐Family Coverage	☐**Dental Plan**	☐ Vision
☐ Birth	☐ Other *include legal document	☐ Tiered Core Plan ☐ EE only☐ EE + spouse ☐ EE + 1 or 2 Children ☐ Family coverage	☐EE only ☐Family coverage	
			Buy Up Plan ☐**EE only**☐ EE + spouse ☐ EE + 1 or 2 Children ☐ Family coverage	☐ EE only ☐ Family coverage
		☐ Waive/Decline (See # 7)	☐ Waive/Decline (See # 7)	☐ Waive/Decline (See # 7)

4. Employee Information						
Last name	First name	Date of birth	Age	Sex ☐ M ☐ F	Social Security #	☐ Single ☐Married ☐Divorced ☐Widowed
Home Address		City	State	Zip code	County	
Home telephone		e-mail address			Other Coverage Indicator: ☐Yes ☐No	

5. Other Health Coverage. Please check one:			
On the day this coverage begins, will you, your spouse/partner, or any of your dependents be covered under any other health plan or policy including Medicare? ☐ Yes (continue completing this sectionand check the other coverage indicator in section five) ☐ No (skip the re			
Provide name, phone number and address of the other coverage / insurance company	Policy / certificate number	Effective date / /	
Policy / certificate holder's name	Policy holder's ID number	Date of birth / /	Relationship to applicant

If you and / or your dependents are enrolled in Other coverage including Medicare complete the following:				
Enrollee's names (s)	Medicare / Medicaid ID#	Medicare Part A Effective date / /	Medicare part B Effective date / /	ESRD onset date / /
Enrollee's names (s)	Medicare / Medicaid ID#	Medicare Part A Effective date / /	Medicare part B Effective date / /	ESRD onset date / /
Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐End State Renal Disease (ESRD)				

6. Family Information (Spouse/Partner and dependents to be added/changed/cancelled) SUPPORTING DOCUMENTATION MUST BE INCLUDED WITH THE ENROLLMENT FORM – TAX DOCUMENTATION/BIRTH CERTIFICATES					
(1) ☐Add ☐ Cancel	Last name		First name,		MI
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐ Spouse ☐Child ☐Partner ☐Step Child		Other Coverage Indicator: ☐ Yes ☐ No
If the dependent's address is different than the employee, please provide full address.					
(2) ☐Add ☐ Cancel	Last name		First name,		MI
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐ Child ☐Partner's Child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					
(3) ☐Add	Last name		First name,		MI

☐ Cancel					
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's Child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					

(4) ☐Add ☐ Cancel		Last name		First name,	MI
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					
(5) ☐Add ☐ Cancel		Last name		First name,	MI
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					

7.Waive/Decline coverage for employee and / or any eligible dependent not enrolling (Please skip to section 8 if not waiving/declining any coverage type)

Check all that apply. Waive/Decline: ☐ Health ☐ Dental ☐ Vision ☐ All

I decline coverage for: ☐Myself ☐Spouse/Partner ☐Dependent Children ☐Myself and all dependents	I Decline coverage due to the existence of other coverage: ☐ Spouse/Partner Employer's Plan ☐VA Eligibility ☐ Individual Plan ☐ Medicare/Medicaid ☐No other coverage at this time
Name of Employer where the above is covered by insurance (if applicable) _____ _____ Carrier: ☐ Other carrier (give name, ID#)	I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, or at the next open enrollment.
Employee signature to waive/decline coverage:	Date:

8.Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

(a) I authorize deduction from my wages if necessary for the required payment for the benefit for which I, or any dependents have applied.	I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. I represent that the answers given to all questions on this enrollment form are true and accurate to the best of my knowledge and I understand they are being relied on by UHC, Delta Dental, and/or VSP in accepting this application. Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other plan, or other person, files an application for insurance or other form of health care coverage 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. I confirm that the information I have provided on this form is complete and accurate. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative. By signing this form, I understand that knowingly providing false or misleading information in this form may result in any or all of the following actions by Columbus State Comminty College: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.
(b) I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/ or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.	
(c) I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.	
(d) I understand that the health benefit plan that I selected provides reimbursement for certain costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expense which I have incurred may not be covered by my health plan.	
(e) I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.	
(f) I attest that I have reviewed the Dependent Eligibility Definitions and that the information and documentation I am submitting are true and accurate.	
Employee signature to enroll in selected benefit plans:	**Date** / /