ENROLLMENT FORM
NORTH RIDGEVILLE BOARD OF EDUCATION HEALTH PLAN

SECTION I -- General Information

This is an: ☐ Initial Form ☐ Amended Form ☐ Rehire of Employee ☐ Open Enrollment

Job Classification: ☐ Certified ☐ Non-Certified

Union Membership: ______________________

Building Location: ______________________

If amended form, indicate nature of change:
☐ Cancel ☐ Change to Other Health Insurance
☐ Retired ☐ Addition of Dependent ☐ Drop Dependent
☐ COBRA ☐ Name Change ☐ Change of Address
☐ Other -- Describe ______________________

SECTION II -- Employee Information

Employee Last Name:	First Name:	Middle Initial:	☐ Male ☐ Female	Date of Birth: / / Mo/Day/Yr
Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed	Insurance Effective Date: / / Mo/Day/Yr	Employment Date: / / Mo/Day/Yr	Employee S.S.#:	

Employee Street Address ______________________ Home Phone (   ) __________

City __________ County __________ State ______ Zip Code ________ Work Phone (   ) __________

SECTION III -- Other Health Insurance

Do you or any of your family members have other health/dental insurance? ☐ YES ☐ NO ☐ Active ☐ Retired

If YES, employed by: ______________________ Names of Insured: ______________________

Name of other medical insurance carrier: ______________________ Name of other dental insurance carrier: __________

Address: ______________________ Policy No. __________ ☐ Single or ☐ Family policy Eff. Date: __________

Are you covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. __________ Eff. Date __________

Is your spouse covered by Medicare? ☐ YES ☐ NO IF YES, Medicare No. __________ Eff. Date __________

SECTION IV -- Health Insurance Plans

	Coverage for Myself			Coverage for My Eligible Dependents		
	I **Do Want** Coverage for Myself	I **Do Not Want** Coverage because: I am covered under my Spouse's Plan	Other Reasons	I **Do Want** Coverage for my eligible dependents listed in Section V	I **Do Not Want** Coverage for my eligible dependents because: They are covered under my Spouse's Plan	Other Reasons
A. Medical PPO /Drug Plan	☐	☐	☐	☐	☐	☐
C. Dental Plan	☐	☐	☐	☐	☐	☐
D. Vision Plan	☐	☐	☐	☐	☐	☐
E. Medical PPO Plan B High Deductible Plan	☐	☐	☐	☐	☐	☐

SECTION V – Dependents

Names (Last, First, Middle Initial)* See Required Documentation to add dependent(s)	**Birthdate (Mo/Day/Yr)**	**Sex M/F**	**Social Security Number**	**Dependent Status**
Spouse				
Child				☐ Adult Child (26-28) ☐ Disabled
Child				☐ Adult Child (26-28) ☐ Disabled
Child				☐ Adult Child (26-28) ☐ Disabled
Child				☐ Adult Child (26-28) ☐ Disabled

Legal Documents (court decree, guardianship papers, etc) must be attached to this application if relationship is marked other.
Adult Dependent Child Certification form must be attached to this application if dependent is age 26 or older and the Adult Child status is marked

Waiver Instructions: If you have declined any coverage offered by your employer for yourself or your dependents, you must complete a separate waiver form. If you decline medical coverage for you and your family because you have provided documentation showing that you are covered by your spouse's plan, you must provide documentation showing that you are covered by your spouses plan if benefits are provided at no cost to you.

Authorization: I hereby authorize any provider, insurance company, employer or organization to release any information regarding any health treatment or benefits payable, including disability or employment related information to the plan administrator or its authorized agent for the purpose of validating and determining benefit payable under this plan. • I understand that payments will be made directly to the provider. • I accept the benefits provided by my employer's group plan and authorize deductions from my earnings of the required contributions, if any, toward the cost of benefits. My authorization for deduction applies only if employee contributions are required. • A photocopy of this authorization shall be considered as effective and valid as the original. • I certify that this foregoing information is true and correct.

______________________ / / ______________________ / /
Employee's Signature Date Verified by School Administrator Date

NORTH RIDGEVILLE BOARD OF EDUCATION
REQUIRED DOCUMENTATION TO ADD DEPENDENT(S)

You must provide the following documentation to add your dependent(s) to the medical and/or prescription drug plan. Please make sure the required documentation is attached to the enrollment form.

Your dependent will not be added until you provided the required documentation.

REQUIRED DOCUMENTATION

<u>For Spouse:</u>

- A copy of the marriage certificate; and
- A copy of either of the following (to confirm current relationship status): (i) the front page of the latest federal tax return or (ii) a recent household document (e.g., recurring monthly bill, bank statement); and
- The completed Working Spouse Certification Form (if applicable)

<u>For Children (up to age 26):</u>

- A copy of the child's birth certificate/hospital birth record or adoption certificate, or a court order; and
- For stepchildren only, the above documentation required for a spouse.

North Ridgeville City School District
MANDATORY ENROLLMENT FOR SPOUSAL COVERAGE
CERTIFICATION FORM

To the Policyholder:
The North Ridgeville Board of Education must have verification of mandatory spousal status in order to provide coverage for your spouse. You and your spouse must complete and sign this form. Once the form has been completed, please forward it to North Ridgeville Treasurer's Office.

1. **Employee Name: ______________________ Policy Number:__________________________________**

2. **Spouse Name: ______________________________**

3. **Is your spouse employed? ☐ Yes ☐ No If Yes, ☐ Full-time ☐ Part-time**

4. **Name, address of spouse's employer and telephone number:___________________________________**
   Employer name

   ____
   Address *Telephone number*

5. **Does spouse's employer offer health insurance ☐ Yes ☐ No**

6. **If, yes, is spouse enrolled? ☐ Yes ☐ No**

7. **If yes, identify the policy number, effective date, name and address of the insurance carrier:**

   ____
   Medical Policy number *Insurance Co. Name* *Address* *Effective Date*

   ____
   Drug Policy number *Insurance Co. Name* *Address* *Effective Date*

8. **If yes, indicate type of coverage: ☐ Medical ☐ Drug ☐ Dental ☐ Vision ☐ Single or ☐ Family Policy**

9. **If yes, is the medical plan a Health Savings Plan? ☐ Yes ☐ No**

10. **If no, explain why your spouse is not enrolled**: ____

11. **Does your spouse's employer's health plan conduct an annual open enrollment period ☐ Yes ☐ No**

12. **If yes, when is the open enrollment period ___________________________**

I certify that the above information is correct to the best of my knowledge. I agree to permit the North Ridgeville to contact my spouse's employer to verify this information. I understand that non-compliance with the mandatory spousal eligibility requirement can result in loss of insurance coverage for myself and my dependents.

______________________________ ____________________________________
Employee Signature/Date **Spouse Signature/Date**