MUTUAL HEALTH SERVICES℠

# ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Change ☐ Termination Effective Date: ___/___/___

Reason for Change: _____

| EMPLOYER: UNITED LOCAL SCHOOLS | DIVISION: (select one in each set) ☐ Administrators ☐ Classified ☐ Certified ☐ Active ☐ COBRA |
|---|---|
| EMPLOYEE NAME: *Last, First, Middle:* | |
| ADDRESS: *Number & Street:* | *Apt. #:* |
| *City:* *State:* *Zip:* *Phone:* | |

| ☐ Male ☐ Female | HIRE/REHIRE DATE: | DATE OF BIRTH: | SOCIAL SEC. #[1]: . . | CURRENT MARITAL STATUS ☐ single ☐ widowed ☐ married ☐ divorced | IF STATUS CHANGE: Date of change / / |
|---|---|---|---|---|---|

[1]Social Security numbers are required for all participants (employee and dependents) of the plan. This number will not appear on your ID card. CMS Reporting requires the plan to report this information to Medicare administration.

**BENEFIT SELECTIONS:**

| | | |
|---|---|---|
| MEDICAL BENEFITS | ☐ Single | ☐ Family |
| VISION BENEFITS | ☐ Single | ☐ Family |
| DENTAL BENEFITS | ☐ Single | ☐ Family |
| PRESCRIPTION BENEFITS | ☐ Single | ☐ Family |

PLAN SELECTION: ☐ SuperMed PPO ☐ SuperMed MEC

LIFE BENEFITS

| | | | |
|---|---|---|---|
| BASIC LIFE ONLY | ☐ Yes | ☐ No | All members have life insurance – Please complete the beneficiary info on next page. |
| LIFE AMOUNT | | | |
| LIFE INS CLASS | | | |

## DEPENDENTS TO BE ENROLLED

| LAST NAME, FIRST NAME, MID INIT | RELATIONSHIP[3] | SEX | BIRTH DATE | SOCIAL SECURITY #[1] | BENEFITS |
|---|---|---|---|---|---|
| Spouse: | | ☐M ☐F | | | ☐ M ☐ D ☐ V ☐ Rx |
| [2]Child: | | ☐M ☐F | | | ☐ M ☐ D ☐ V ☐ Rx |
| [2]Child: | | ☐M ☐F | | | ☐ M ☐ D ☐ V ☐ Rx |
| [2]Child: | | ☐M ☐F | | | ☐ M ☐ D ☐ V ☐ Rx |
| [2]Child: | | ☐M ☐F | | | ☐ M ☐ D ☐ V ☐ Rx |

[2]Proof of eligibility may be required. [3]Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify).

**PRIOR COVERAGE** Did you have prior coverage before enrolling with United Local Schools? ☐ Yes ☐ No If YES: ▼
Please submit a Certificate of Creditable Coverage to Mutual Health Services, PO Box 5700, Cleveland, OH 44101

**OTHER INSURANCE**
☐ No members of my family are covered by any other plan of insurance.
☐ The following members are covered by other insurance plans as noted below.

| | EMPLOYEE | SPOUSE | CHILD: _____ | CHILD: _____ |
|---|---|---|---|---|
| Policy Holder's Name: | | | | |
| Insurance Company: | | | | |
| Coverage Tier: | ☐ SINGLE ☐ FAMILY | ☐ SINGLE ☐ FAMILY | ☐ SINGLE ☐ FAMILY | ☐ SINGLE ☐ FAMILY |
| Coverage Type: | ☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION | ☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION | ☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION | ☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION |

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Mutual Health Services. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature of Employee _____ Date Signed _____

**COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED**

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Reason for Waiving _____

Signature of Employee _____ Date Signed _____

Signature of Employer _____ Date Signed _____

LIFE INSURANCE

| | |
|---|---|
| Full Name of Beneficiary(ies): | Address: |
| Relationship: | |
| Contingent Beneficiary: | Address: |
| Relationship: | |

_____ _____

Signature of Employee: Date:

INSTRUCTIONS FOR NAMING BENEFICIARY

1. Give complete name of beneficiary and relationship to you (indicate "non-relative" and present address).

2. If beneficiary is a married woman, show given name (Mary J. Doe not Mrs. John Doe).

3. Unless other wise provided, proceeds will be paid in equal shares to those primary beneficiaries who survive you, but if no primary beneficiaries survive you, such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive you.

NOTE: You may change your beneficiary at any time in accordance with the conditions and provisions of the group policies. You must complete a new enrollment card when changing beneficiaries.