

SOUTH CENTRAL OHIO INSURANCE CONSORTIUM

Enrollment/Change Form

(Please print or type)

Employer Name: _____
 Division/Class: _____

Received: _____
 Entered: _____
 Verified: _____
 Cards Sent: _____

ENROLLMENT	ELECT/ADD COVERAGE	DELETE COVERAGE	CHANGE
New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Plan Change <input type="checkbox"/> Special Enrollment <input type="checkbox"/>	<input type="checkbox"/> Medical - Employee <input type="checkbox"/> Dependents <input type="checkbox"/> <input type="checkbox"/> Dental - Employee <input type="checkbox"/> Dependents <input type="checkbox"/> <input type="checkbox"/> Life <input type="checkbox"/> <input type="checkbox"/> Optional Life	All <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/>	For Dependents <input type="checkbox"/> (Please Complete Section III, below) Name <input type="checkbox"/> Formerly _____ Address <input type="checkbox"/> Other <input type="checkbox"/> (Please Complete Section II, below)

II. EMPLOYEE INFORMATION				
Employer Name	Employer Group Number	Employee Social Security Number	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Employee First Name	M.I.	Last Name		
Street Address		City	State	Zip
Work Phone ()	Home Phone ()	Life Insurance Amt.	Date of Employment	Effective Date of Coverage/Change(s)

III. DEPENDENT INFORMATION							
Relationship To Employee	First Name	M.I.	Last Name	Gender M/F	Date of Birth MM/DD/YY	Social Security Number	Zip Code if reside out of area
Spouse							
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild							
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild							
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild							
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild							

IV. MARITAL STATUS AND OTHER HEALTH INSURANCE COVERAGE			
<input type="checkbox"/> Single	<input type="checkbox"/> Married	Do you or any member of your family have other health insurance coverage?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	* IF YES, PLEASE COMPLETE ALL APPLICABLE INFORMATION IN SECTION VIII ON THE BACK OF THIS FORM. If married, is your spouse employed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Employer's Name: _____			

V. COVERAGE SELECTION	
<input type="checkbox"/> I hereby request the coverage for which I am eligible, as elected in Section I above, and authorize payroll deductions of the amount required to cover my share of the contributions. I certify that the dependents listed are my dependents within the definition contained in the plan documents of my employer/group. I agree to notify the Plan Administrator if/when there is a change in any dependent's status. I have signed and agree to the "Authorization for Release of Information" on the back of this form.	
<input type="checkbox"/> I hereby decline medical <input type="checkbox"/> and/or dental <input type="checkbox"/> coverage under my employer/group health plan for myself <input type="checkbox"/> and/or my dependents <input type="checkbox"/> . I understand if I decline coverage, I may not enroll until the next Open Enrollment Period or within thirty (30) days of an event that qualifies as a "Special Enrollment" event.	
IMPORTANT NOTE TO NEW ENROLLEES: PRE-EXISTING CONDITIONS EXCLUSION DISCLOSURE NOTICE The medical plan contains a Pre-Existing Condition Exclusion Period of 12 months. A Covered Person has the right to reduce the Pre-Existing Condition Exclusion Period by presenting a Certificate of Creditable Coverage provided by a prior health plan. By presenting a Certificate of Creditable Coverage, the Pre-Existing Condition Exclusion Period will be reduced by the individual's days of Creditable coverage as of the enrollment date. I acknowledge by signing this Enrollment Form that I as well as any of my dependents enrolled may be subject to the Pre-Existing Conditions Exclusion.	
Employee's Signature: _____	Date: _____

VI. CREDITABLE COVERAGE	VII. TO BE COMPLETED BY EMPLOYER
NEW ENROLLEES ONLY - Do you or any eligible dependents have Creditable Coverage from a prior Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	Effective Date of Enrollment/Change: _____
Please attach Certificates of Creditable Coverage or other proof of Creditable Coverage to this Enrollment Form. Questions regarding Creditable Coverage should be directed to your Employer's benefits department.	Type of Change: <input type="checkbox"/> Termination <input type="checkbox"/> Coverage Change
Important Note: Without proof of Creditable Coverage, the Plan will impose a Pre-Existing Conditions Exclusion Period of 12 months on all new enrollees.	Reason for Change: _____ (specify event)
	Date of event that is the reason for change: _____

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

VIII. OTHER HEALTH INSURANCE COVERAGE - POLICY HOLDER INFORMATION

Medical Coverage

Policy Holder's Name: _____ Relationship to Employee: _____
 Policy Holder's Date of Birth: _____ Effective Date of Other Coverage: _____
 Insurance Company's Name: _____
 Name(s) of Dependent(s) Covered: _____

Dental Coverage

Policy Holder's Name: _____ Relationship to Employee: _____
 Policy Holder's Date of Birth: _____ Effective Date of Other Coverage: _____
 Insurance Company's Name: _____
 Name(s) of Dependent(s) Covered: _____

Other Coverage

Policy Holder's Name: _____ Relationship to Employee: _____
 Policy Holder's Date of Birth: _____ Effective Date of Other Coverage: _____
 Insurance Company's Name: _____
 Name(s) of Dependent(s) Covered: _____

IX. LIFE INSURANCE INFORMATION

Class	Amount	Optional Life Yes <input type="checkbox"/> No <input type="checkbox"/>
Beneficiary Name	Beneficiary SSN	Relationship to Employee
Contingent Beneficiary Name	Beneficiary SSN	Relationship to Employee

Salary Redirection Agreement

I have enrolled for certain insurance coverage(s) and understand that my insurance premiums and/or Flexible Savings Account(s)(FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an equal amount to the insurance premiums and/or FSA account election amount for each payroll period throughout the plan year. The amount of my required contribution is set forth on a schedule that has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. If the rate change is brought on by the third-party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. "Employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes, therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

I understand and agree that (initial all):

INITIAL: On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in family status" occurs (as defined under the Internal Revenue Code), and the change is caused by and consistent with the "change in family status." I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.

INITIAL: Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

INITIAL: In addition to and without limiting in any way my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

INITIAL: Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.

AUTHORIZATION FOR RELEASE OF INFORMATION:

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub.L.No 104-191, and relevant unenumerated federal and state statutes, I hereby authorize the use or disclosure of my protected health information (PHI) and individually identifiable health information (IIHI) as follows:

I hereby authorize the release of any medical records or information, including PHI and IIHI, concerning claims, conditions, payment, health care operation or treatment of myself and any dependents listed on the front of this form, by any provider of health services, any insurer, or other organization or person to the Plan, its sponsor, or other representative. Such information includes, but is not limited to medical records containing PHI, IIHI and specific medical history, including sensitive services such as mental health, substance abuse, reproductive health, sexually transmitted or other communicable diseases, and HIV virus or AIDS, contained in such records. The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

This information will be used for purposes related to providing welfare benefit coverage, including, but not limited to the following: (1) processing this enrollment/change form; (2) detecting or preventing fraud or misrepresentation; (3) internal and external audits; (4) administration of claims; (5) claims reviews; (6) peer review; (7) health care research; (8) public health reporting; (9) affiliates; (10) coordination of benefits; (11) subrogation; and (12) disease management/prevention.

I understand that this information may also be furnished to other entities providing services on behalf of the Plan such as, but not limited to; (1) claims administrators; (2) pharmacy benefit managers; (3) insurers; (4) re-insurers; (5) stop-loss carrier; (6) agents; (7) subsidiaries; (8) affiliates; (9) governmental authorities; and (10) in response to a legal order. Such entities will be advised that the information must be kept confidential as required by law, and should not be used for any unlawful purpose.

My signature below authorizes coverage for myself and my eligible dependents enrolled under the Plan. I am acting as agent and representative of such dependents. For purposes of processing this enrollment/change form, this authorization is valid for 30 months from the date signed. For all other purposes this authorization is valid while the Plan remains in effect.

A photocopy of this authorization is valid as the original. I understand I may request a photocopy for my own records.

Signature: _____ Date: _____