Lake County Government Enrollment Form

PLEASE TYPE OR PRINT EMPLOYEE: Complete all areas. Be sure to include Social Security number.

Every eligible person must be given the opportunity to enroll for coverage.

FOR OFFICE USE ONLY	EFF. DATE	MEDICAL	DENTAL	LIFE	AD&D	WKLY	VISION	RX

1. EMPLOYEE INFORMATION

EMPLOYEE'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH Month Day Year	SOCIAL SECURITY NUMBER

STREET ADDRESS CITY STATE ZIP

HOME TELEPHONE: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER OCCUPATION OR TITLE

LIFE INSURANCE BENEFICIARY: _____ RELATIONSHIP
(if more than one attach additional sheet) FIRST MIDDLE LAST

DATE OF EMPLOYMENT Month	Day	Year	HOURS WORKED PER WEEK	EARNINGS ☐ YEAR ☐ WEEK ☐ MONTH ☐ HOUR $_____

2. DEPENDENT INFORMATION

Do you want dependent coverage? ☐ YES ☐ NO If Yes, list all dependents: Fill in the Following Information for each Dependent Covered *(PROOF OF DEPENDENT STATUS MAY BE REQUIRED)*

IMPORTANT If your spouse is employed, and his/her employer offers medical coverage for which he/she is eligible, they must be covered by their employer's plan. Proof required. Dependent Spouse Health Insurance Verification Form must be completed.

DEPENDENT LAST NAME (ONLY IF DIFFERENT FROM ABOVE)	FIRST NAME	M.I.	DATE OF BIRTH Month Day Year	SEX (M or F)	RELATIONSHIP	SOCIAL SECURITY NUMBER

3. OTHER INSURANCE

Is your spouse Employed? ☐ Yes ☐ No	If yes, please give name and address of spouse's employer:	
If yes, Is your spouse offered health insurance? ☐ Yes ☐ No	If Yes, please give name and policy number of insurance carrier:	Who is covered under your spouses' policy? ☐ Yourself ☐Yourself/Spouse ☐ Spouse Only ☐ Entire Family ☐ Child/Children

I hereby (1) apply for plan benefits, (2) authorize my employer to make the necessary deduction from my wages or salary for the contributions, if any, required of me for the coverage, (3) designate the beneficiary name on this card to receive the proceeds, if any, payable in the event of my death. This beneficiary designation supersedes and cancels all prior beneficiary designations, and (4) I represent that all the information supplied in this application is true and complete. I understand that any misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

SIGNATURE OF EMPLOYEE (if you want coverage – sign here) DATE SIGNED (mm/dd/yy)

X _____ _____

ONLY SIGN IF YOU DO <u>NOT</u> WANT COVERAGE: Waiver of coverage for employee and / or any eligible dependent not enrolling:

☐ I certify that the benefit plan(s) elected by my employer have been explained to me and I understand them fully. After due consideration, I have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends, marriage, birth, adoption or placement for adoption; or within 60 days of the loss of Medicaid/CHIP or eligibility for a subsidy (state premium assistance program). My dependent(s) or I may be subject to waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

Signature of Employee (Only sign here if you do <u>NOT</u> want coverage)

_____ Date _____

(Rev 7/21/15:ljl)