

ONONDAGA COUNTY EMPLOYEE BENEFITS ENROLLMENT

GROUP NO.	DEPT./PKG. NO.	DIV./PKG. NO.	UNION CODE	EMPLOYEE KEY NO. (INCLUDE S.S.NO.)
ORIG. EMPLOYMENT DATE	TERMINATION DATE	RETIREMENT DATE	REINSTATEMENT DATE	POSITION JOB TITLE
LINE NUMBER	CHECK (✓) ONE: <input type="checkbox"/> 101 <input type="checkbox"/> 103		<input type="checkbox"/> ACTIVE/FULL TIME <input type="checkbox"/> ACTIVE/PART TIME	DATE STATUS EFFECTIVE
CHECK (✓) ONE: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> LEAVE OF ABSENCE <input type="checkbox"/> DECEASED <input type="checkbox"/> TERMINATION <input type="checkbox"/> COBRA <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> SURVIVOR <input type="checkbox"/> ADD/CHANGE (DESCRIBE BELOW)		IF PART TIME, NO. HRS. WORKED PER P.P.		

INSTRUCTIONS: ALL APPROPRIATE AREAS MUST BE COMPLETED AND THE FORM SIGNED

SOCIAL SECURITY NO.	EMPLOYEE LAST NAME	FIRST NAME	INITIAL
STREET ADDRESS		CITY	STATE ZIP

MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> LEGALLY SEPARATED	DATE OF MARRIAGE	BIRTHDATE	SEX, M-F
PCP CHOICE		ESTABLISHED PAT. <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU PRESENTLY EMPLOYED ELSEWHERE? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF OTHER OR PREVIOUS EMPLOYER		ARE YOU RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

TYPE OF BENEFITS HEALTH <input type="checkbox"/>	NAME OF CARRIER/MEDICARE HIC NO.	MEDICARE A EFF. DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>
DENTAL <input type="checkbox"/>	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>

LAST NAME <input type="checkbox"/> SUPPLY MARRIAGE CERTIFICATE <input checked="" type="checkbox"/> VERIFIED	FIRST NAME	INITIAL	SPOUSE SOCIAL SECURITY NO.
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BIRTHDATE	SEX, M-F	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE HIC NO.
PCP CHOICE		ESTABLISHED PAT. <input type="checkbox"/> YES <input type="checkbox"/> NO	DOES YOUR SPOUSE HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICARE A EFF. DATE MEDICARE B EFF. DATE	
TYPE OF BENEFITS HEALTH <input type="checkbox"/>	NAME OF CARRIER/ADMINISTRATOR		EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	
DENTAL <input type="checkbox"/>	NAME OF CARRIER/ADMINISTRATOR		EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/>	

IF A DEPENDENT IS OVER AGE 18, A STUDENT DEPENDENT CERTIFICATION MUST BE COMPLETED (SUPPLY BIRTH CERTIFICATE) VERIFIED

LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT SOC. SEC. NO.	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP CHOICE		ESTABLISHED PAT. <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE		
LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT SOC. SEC. NO.	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP CHOICE		ESTABLISHED PAT. <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE		
LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE DISABLED	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT SOC. SEC. NO.	EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	COLLEGE FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP CHOICE		ESTABLISHED PAT. <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE		

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, PLEASE USE ANOTHER FORM, BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER ON ANY ADDITIONAL FORMS.

TYPE	OPTION	COVERAGE	COVERAGE	EFFECTIVE DATE	CANCELLATION DATE	CODE
HEALTH <input type="checkbox"/> YES <input type="checkbox"/> NO	ONONDAGA CO. <input type="checkbox"/> HMO <input type="checkbox"/> <u> </u> NAME OF HMO	INDIVIDUAL <input type="checkbox"/>	FAMILY <input type="checkbox"/>			
DENTAL <input type="checkbox"/> YES <input type="checkbox"/> NO	ONONDAGA CO. DENTAL PLAN <input type="checkbox"/>	INDIVIDUAL <input type="checkbox"/>	FAMILY <input type="checkbox"/>			

DATE: _____ SIGNATURE _____ DATE: _____ EMPLOYER'S REPRESENTATIVE _____

RELEASE • I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents). • I hereby accept responsibility for payment of any portion of the premium and authorize my employer to make the required deductions. • I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information. I understand that the OnPoint coverage is comprised of the POS in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provides the highest level of coverage.

DESCRIBE ADD/CHANGE: RELEASE - You must sign and date this form to be eligible for insurance. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.