ONONDAGA COUNTY EMPLOYEE BENEFITS ENROLLMENT

EMPLOYER SECTION

GROUP NUMBER	UNION CODE	EMPLOYEE ID#

ORIG. EMPLOYMENT DATE	TERMINATION DATE	RETIREMENT DATE	POSITION JOB TITLE

☐ 101 ☐ 103	☐ ACTIVE/ FULL TIME ☐ ACTIVE/ PART TIME	PART-TIME: # OF HRS.WORKER PER PAY PERIOD

CHECK (✓) ONE: ☐ NEW HIRE ☐ RETIRED ☐ LEAVE OF ABESENCE ☐ TERMINATION ☐ ADD/CHANGE (DESCRIBE BELOW)

EMPLOYEE INFORMATION

SOCIAL SECURITY NO.	EMPLOYEE LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER	BIRTHDATE	SEX ☐ M ☐ F

MARITAL STATUS:	☐ MARRIED	☐ SINGLE	☐ DIVORCED	☐ WIDOWED	☐ LEGALLY SEPERATED	DATE OF MARRIAGE

DO YOU HAVE ADDITIONAL INSURANCE COVERAGE?

TYPE OF BENEFITS				
☐ HEALTH	NAME OF CARRIER/MEDICARE HIC NO.	MEDICARE A EFF DATE: MEDICARE B EFF DATE:	CANCELLATION DATE	COVERAGE ☐ INDIVIDUAL ☐ FAMILY
☐ DENTAL	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE ☐ INDIVIDUAL ☐ FAMILY

SPOUSE INFO.

LAST NAME	FIRST NAME	INITIAL	SPOUSE SOCIAL SECURITY NO.

BIRTHDATE	SEX ☐ M ☐ F	EMPLOYED ☐ Y ☐ N	DISABLED ☐ Y ☐ N	DATE DISABLED	MEDICARE ☐ Y ☐ N	MEDICARE HIC NO.

DOES YOUR SPOUSE HAVE ADDITIONAL INSURANCE COVERAGE?	☐ Y ☐ N	MEDICARE A EFF DATE: MEDICARE B EFF DATE:

TYPE OF BENEFITS				
☐ HEALTH	NAME OF CARRIER/MEDICARE HIC NO.	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE ☐ INDIVIDUAL ☐ FAMILY
☐ DENTAL	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE ☐ INDIVIDUAL ☐ FAMILY

DEPENDENT INFO.

LAST NAME	FIRST NAME	INITIAL	DEPENDENT SOCIAL SECURITY NO.

BIRTHDATE	SEX ☐ M ☐ F	COLLEGE FULLTIME ☐ Y ☐ N	DISABLED ☐ Y ☐ N	DATE DISABLED

LAST NAME	FIRST NAME	INITIAL	DEPENDENT SOCIAL SECURITY NO.

BIRTHDATE	SEX ☐ M ☐ F	COLLEGE FULLTIME ☐ Y ☐ N	DISABLED ☐ Y ☐ N	DATE DISABLED

LAST NAME	FIRST NAME	INITIAL	DEPENDENT SOCIAL SECURITY NO.

BIRTHDATE	SEX ☐ M ☐ F	COLLEGE FULLTIME ☐ Y ☐ N	DISABLED ☐ Y ☐ N	DATE DISABLED

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

BENEFITS

TYPE		OPTION	COVERAGE	COVERAGE	EFFECTIVE DATE	CANCELLATION DATE	CODE
HEALTH	☐ Y ☐ N	☐ ONPOINT/EXCELLUS ☐ MVP		☐ INDIVIDUAL ☐ FAMILY			
DENTAL	☐ Y ☐ N	☐ ONONDAGA COUNTY DENTAL PLAN		☐ INDIVIDUAL ☐ FAMILY			

SIGNATURE:____ DATE: ___________

EMPLOYER'S REPRESENTATIVE:__________________________________ DATE:_________

RELEASE • I acknowledge and agree that by signing this enrollment form, I and everyone else who is covered is bound by the terms and conditions of the contract 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. I hereby accept responsibility for payment of any portion of the premium and authorize my employer to make the required deductions.

DESCRIBE ADD/CHANGE:	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.