

ONONDAGA COUNTY EMPLOYEE BENEFITS ENROLLMENT

EMPLOYER SECTION	GROUP NUMBER		UNION CODE		EMPLOYEE ID#			
	ORIG. EMPLOYMENT DATE		TERMINATION DATE		RETIREMENT DATE		POSITION JOB TITLE	
	<input type="checkbox"/> 101 <input type="checkbox"/> 103	<input type="checkbox"/> ACTIVE/ FULL TIME <input type="checkbox"/> ACTIVE/ PART TIME		PART-TIME: # OF HRS.WORKER PER PAY PERIOD				
	CHECK (✓) ONE: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> RETIRED <input type="checkbox"/> LEAVE OF ABESENCE <input type="checkbox"/> TERMINATION <input type="checkbox"/> ADD/CHANGE (DESCRIBE BELOW)							
EMPLOYEE INFORMATION	SOCIAL SECURITY NO.		EMPLOYEE LAST NAME		FIRST NAME		INITIAL	
	STREET ADDRESS			CITY		STATE		ZIP
	TELEPHONE NUMBER			BIRTHDATE			SEX <input type="checkbox"/> M <input type="checkbox"/> F	
	MARITAL STATUS:	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> LEGALLY SEPARATED	DATE OF MARRIAGE	
	DO YOU HAVE ADDITIONAL INSURANCE COVERAGE?							
	TYPE OF BENEFITS	NAME OF CARRIER/MEDICARE HIC NO.		MEDICARE A EFF DATE:		CANCELLATION DATE		COVERAGE
	<input type="checkbox"/> HEALTH			MEDICARE B EFF DATE:				<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY
	<input type="checkbox"/> DENTAL	NAME OF CARRIER/ADMINISTRATOR		EFFECTIVE DATE		CANCELLATION DATE		COVERAGE
								<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY
	SPOUSE INFO.	LAST NAME		FIRST NAME		INITIAL	SPOUSE SOCIAL SECURITY NO.	
BIRTHDATE		SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYED <input type="checkbox"/> Y <input type="checkbox"/> N	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> N	DATE DISABLED	MEDICARE <input type="checkbox"/> Y <input type="checkbox"/> N	MEDICARE HIC NO.	
DOES YOUR SPOUSE HAVE ADDITIONAL INSURANCE COVERAGE?				<input type="checkbox"/> Y <input type="checkbox"/> N	MEDICARE A EFF DATE: MEDICARE B EFF DATE:			
TYPE OF BENEFITS		NAME OF CARRIER/MEDICARE HIC NO.		EFFECTIVE DATE		CANCELLATION DATE		COVERAGE
<input type="checkbox"/> HEALTH								<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY
<input type="checkbox"/> DENTAL		NAME OF CARRIER/ADMINISTRATOR		EFFECTIVE DATE		CANCELLATION DATE		COVERAGE
								<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY
LAST NAME		FIRST NAME		INITIAL	DEPENDENT SOCIAL SECURITY NO.			
BIRTHDATE		SEX <input type="checkbox"/> M <input type="checkbox"/> F	COLLEGE FULLTIME <input type="checkbox"/> Y <input type="checkbox"/> N	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> N	DATE DISABLED			
DEPENDENT INFO.		LAST NAME		FIRST NAME		INITIAL	DEPENDENT SOCIAL SECURITY NO.	
	BIRTHDATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	COLLEGE FULLTIME <input type="checkbox"/> Y <input type="checkbox"/> N	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> N	DATE DISABLED			
	LAST NAME		FIRST NAME		INITIAL	DEPENDENT SOCIAL SECURITY NO.		
	BIRTHDATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	COLLEGE FULLTIME <input type="checkbox"/> Y <input type="checkbox"/> N	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> N	DATE DISABLED			
	LAST NAME		FIRST NAME		INITIAL	DEPENDENT SOCIAL SECURITY NO.		
	BIRTHDATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	COLLEGE FULLTIME <input type="checkbox"/> Y <input type="checkbox"/> N	DISABLED <input type="checkbox"/> Y <input type="checkbox"/> 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							
	TYPE	OPTION	COVERAGE	COVERAGE	EFFECTIVE DATE	CANCELLATION DATE	CODE	
	HEALTH	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> ONPOINT/EXCELLUS <input type="checkbox"/> MVP	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY				
	DENTAL	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> ONONDAGA COUNTY DENTAL PLAN	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 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.