# SHELBY COUNTY GOVERNMENT
# HEALTH CARE BENEFIT PLANS APPLICATION AND CHANGE FORM

| ENROLLMENT | PLAN SECTION | TYPE OF CHANGE | FOR OFFICE USE ONLY |
|---|---|---|---|
| ☐ TRANSITIONAL ENROLLMENT | ☐ CIGNA PPO SINGLE ☐ FAMILY ☐<br>☐ CIGNA POS SINGLE ☐ FAMILY ☐ | ☐ ADD DEPENDENT (See Below)<br>☐ DROP DEPENDENT (See Below)<br>☐ NAME CHANGE: From _____ To _____<br>CHANGE _____ Date _____<br>PLAN CHANGE: From _____ To _____ | COV. GROUP # EFF. DATE<br>COMMENTS<br>INPUT BY |

## EMPLOYEE/RETIREE INFORMATION

| LAST NAME, FIRST, MI | BIRTH DATE | SOCIAL SECURITY NUMBER | DEPARTMENT | HOME PHONE _____<br>WORK PHONE _____ |
|---|---|---|---|---|
| STREET ADDRESS ☐ CHECK IF NEW | SEX<br>☐ MALE ☐ FEMALE | DATE EMPLOYED | EMPLOYMENT STATUS ☐ ACTIVE ☐ RETIRED | |
| CITY, STATE, ZIP CODE | | EMPLOYEE PRIMARY CARE PHYSICIAN (PCP) | CODE | EXISTING PATIENT<br>☐ YES ☐ NO |

## DEPENDENT INFORMATION

| LAST NAME, FIRST, MI | BIRTH DATE | RELATIONSHIP | SOCIAL SECURITY NUMBER | PCP CODE | EXISTING PATIENT | | |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ YES<br>☐ NO | | |
| | | | | | ☐ YES<br>☐ NO | | |
| | | | | | ☐ YES<br>☐ NO | | |
| | | | | | ☐ YES<br>☐ NO | | |
| | | | | | ☐ YES<br>☐ NO | | |

PROOF OF RELATIONSHIP IS REQUIRED. DEPENDENT STATUS FORM MUST BE COMPLETED ON ALL FULL-TIME STUDENTS, AGE 19 OR OVER.

## OTHER COVERAGE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH INSURANCE, INCLUDING MEDICARE? YES ☐ NO ☐ IF YES, COMPLETE ALL SECTIONS.

| NAME OF POLICY | SOCIAL SECURITY NO. | GROUP NO. | NAME OF COMPANY/ADDRESS |
|---|---|---|---|
| | | | |

| MEDICARE NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE |
|---|---|---|
| | | |

| MEDICARE DEPENDENTS | MEDICARE NO. | EFFECTIVE DATE |
|---|---|---|
| | | |
| | | |

I have read this application and certify that all statements contained are true and complete to the best of my knowledge and belief. I understand any material misrepresentation will result in the cancellation of my coverage retroactive to the original effective date and the denial of all claims plus reimbursement to the health plan of any benefit payments made as a result of the misrepresentation. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in my employee booklet or plan information distributed to me. I authorize any hospital or provider of care to furnish any information, including copies of records pertaining to me or my earnings and remit this amount to the Shelby County Health Care Program for the plan of coverage I have selected.

Signature _____ Date _____

White-Benefits Yellow-Benefits Pink-Employee