

Oakland County Health Plan Enrollment Form

For Deputies Hired On/After 01/01/2000.
(Bargaining Unit 9 & 10)

DPDT _____
DE _____

Employee ID #: _____

Please print your name below:

Your name as it is displayed on your Social Security Card

Last	First	Middle	M <input type="checkbox"/>	Married <input type="checkbox"/>	Date of Birth	
			F <input type="checkbox"/>	Single <input type="checkbox"/>	Birth	

Home Address City State Zip

Home Telephone Work	Social Security No.	Full-time <input type="checkbox"/>	New Hire <input type="checkbox"/>	Date of Hire	
		Part-time <input type="checkbox"/>	Re-hire <input type="checkbox"/>	Hire	

(Mark the Plan of Your Choice for Medical & Dental)	Select One Medical Coverage	Select One Dental Coverage
	<input type="checkbox"/> Comprehensive Major Medical (CMM) (M1, M2, M3) <input type="checkbox"/> BC/BS Blue Preferred Plan (PPO) (P1, P2, P3) <input type="checkbox"/> Health Alliance Plan (HAP) (H1, H2, H3) <input type="checkbox"/> No Medical Coverage (N1, N2, N3) (Please complete "Other Coverage" below) <input type="checkbox"/> Is Your Spouse A County Employee? (NS1, NS2, NS3) (Please complete "Other Coverage" below)	<input type="checkbox"/> Dental Coverage (789) <input type="checkbox"/> No Dental Coverage (16,17,18) (Please complete "Other Coverage" below) <input type="checkbox"/> Is Your Spouse A County Employee? (19,20,21) (Please complete "Other Coverage" below) <input checked="" type="checkbox"/> Vision Coverage (required) - List Dependents below. (10,11,12)

Complete **ONLY** if you are Enrolling in the HAP plan → Primary Physician Physician Code

IMPORTANT - List Family Members you are covering. Please include last name if different from yours. HAP Enrollments Only

NAME	SSN	BIRTH DATE	Sex	Relationship	Primary Physician	Code
Spouse						

Medical Other Coverage Verification:

I am currently enrolled in _____ through my _____'s coverage with _____.

Health Policy Relationship Name of Company or Organization

Dental Other Coverage Verification:

I am currently enrolled in _____ through my _____'s coverage with _____.

Health Policy Relationship Name of Company or Organization

I apply on behalf of myself and eligible family members, as listed, for enrollment in the health plan selected above as currently offered through Oakland County. I hereby revoke all previous enrollment applications executed by me for hospital and medical coverage as made available by Oakland County. Remember, no matter which health plan you choose, you elect a plan not a specific provider. If I selected the NO COVERAGE option, I realize my next opportunity to enroll may be as long as 1 year from this date.

I agree to the terms and conditions on the reverse side of this form and certify that the above information is true and correct.

Subscriber's Signature: _____ Date: _____

Effective Date _____ Group/Suffix _____ Service Code _____

ENROLLMENT FORM TERMS AND CONDITIONS

Your signature on the front side of this form indicates your understanding that Oakland County will enroll you and your eligible dependents for hospital, surgical, medical and prescription drug coverages made available by Oakland County for which you are eligible and which you have not waived or canceled, with the health carrier you have elected and constitutes your authorization to Oakland County or any of its agents to release to all carriers or organizations, as applicable, the information contained on this form.

Your signature on the front side of this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare approved organization or provider of service to release consistent with state and federal laws including the Health Insurance Portability & Accountability Act (HIPAA), any information requested with respect to a claim to the health carrier in which you are enrolled, or to the state or federal government, in situations involving processing or auditing of claims or investigation of fraud.

Your signature on the front side of this form constitutes your authorization to Oakland County, until this authorization is revoked by you in writing, to deduct in advance each month from any earned or accrued wages due you or from pension or retirement benefits due you, such amount as may be necessary to make any contributions required of you. These include, by way of example, but not limited to, amounts for dependent coverage, and county health care contribution amounts.

If in any month you are not eligible to receive any earned or accrued wages or pension or retirement benefits, your signature on the front side of this form constitutes your agreement to pay in cash to Oakland County the full monthly subscription charges on or before the first of the month for which coverage is to be provided.

You may enroll your unmarried children legally residing with you who are either your own, or legally adopted, or those of your spouse by a previous marriage or for which you provide principal support as long as such children reside with you and are dependents within the meaning of the Internal Revenue Service Code. Such children can be covered up to December 31 of the year in which they turn 25. Additional restrictions specific to the plan selected may also apply. Contact the Employee Benefits Unit of the Human Resources Department for further information.

Other terms and conditions apply according to the specific plan in which you are enrolled.

This form should only be used for those employees hired in Bargaining Unit 10 on/after 01/01/2000.

Revised: 05/2004