

Oakland County Enrollment Form

Office Use Only:
 DPDT _____
 DE _____

Part-Time Eligible Vision/Dental Plan

<input type="checkbox"/> Vision Only Eligible after 6 months	<input type="checkbox"/> Dental Only Eligible after 1 year
--	--

Contact Employee Benefits for more information.

Employee ID#:								
Your Name	Last	First	M.I.	M <input type="checkbox"/>	Married <input type="checkbox"/>	Date of Birth		
				F <input type="checkbox"/>	Single <input type="checkbox"/>			
Home Address			City	State	Zip			
Home Telephone	Work	SSN:			Date of Hire			

IMPORTANT - List Family Members you are covering. Last Name if different from yours. See reverse side for dependent eligibility.

Name	SSN	Birth Date	Sex	Relationship
Spouse:				
Dependent(s):				

Are you or any enrolled dependents Medicare eligible?

Relationship	Medicare or SS#	Effective Dates	
		Part A	Part B
Yourselves			
Spouse			
Dependent (Name)			

I apply on behalf of myself and eligible family members, as listed, for enrollment in the plan(s) selected above as currently offered through Oakland County. I hereby revoke all previous enrollment applications executed by me for vision and/or dental coverage as made available by Oakland County.

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

Personnel Department Use Only:
Group Authorization Signature _____

Subscriber's Signature _____ Date _____

Effective Date _____

Group/Suffix _____

Vision and Dental Coverage

Terms and Conditions

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 provide the coverages selected on the front side of this form.

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 charges on or before the first of the month for which coverage is to be provided.

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 services to release any information requested with respect to a claim to Blue Cross/Blue Shield or 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 acknowledges your understanding that to be eligible for dependent vision coverage your child must be unmarried, legally reside with you and dependent on you for more than half their support as defined by the Internal Revenue Code, and as such been reported on your most recent Federal Income Tax return. Such children can be covered through December 31 or the year in which they turn 25.

Your signature on the front side of this form acknowledges your understanding that to be eligible for dependent dental coverage your child must be unmarried, legally reside with you and dependent on you for more than half their support as defined by the Internal Revenue Code, and as such been reported on your most recent Federal Income Tax return. Such children can be covered through December 31 of the year in which they turn 25. Contact Employee Benefits for information on dependent children.