County Employee Benefits Consortium of Ohio

CEBCO

Counties Uniting for Affordable Health Benefits

209 East State Street
Columbus, Ohio 43215
Toll Free - Ohio Only 1-888-757-1904

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

CHANGE REQUEST FORM

Send to: Kelly Bidlack
HR Specialist
Commissioners' Office

County: Geauga

Location / Dept #: ______

FOR OFFICE USE ONLY CHANGE EFFECTIVE: ______ EXCLUSIONS: ______
DATE PROCESSED: ______ ISSUED: ______

PLEASE READ CAREFULLY AND *PRINT* IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.

☐ Employer ______ Employee ______

Account No. 10270 Social Security Number ______ Telephone ( )

Add Spouse ☐

Name ______ Date of Birth ______

Date of Marriage ______ Spouse employed ☐ Yes ☐ No Spouse's S.S. No. ______

Employed By ______ (Company Name) ______ (City, State of Employment)

Is your spouse covered or insured under any other medical coverage (**including Medicare and other government plans**)?

☐ No ☐ Yes If **yes,** indicate who the carrier is: ______

Add Children ☐

Full Name (Please Print Clearly)	SSN	Date of Birth	Natural Child	Adopted Child*	Step-Child	Legal Guardian	Male (M) Female (F)	Over-Age Dependent (Y/N)**	AGE

Please attach **copies of the court orders or legal documents creating this relationship.*

Spouse employed ☐ No ☐ Yes Employed By ______ Date of Marriage ______

Are children covered or insured under any other medical coverage (**including Medicare and other government plans**)?

☐ No ☐ Yes If **yes**, indicate who is covered under this other coverage, and who the carrier is: ______

Are any of the other Dependents listed above in the legal custody of another Person? ☐ No ☐ Yes If **Yes** (See Box Below)

Dependent	Person with Legal Custody	Relationship	Address of Custodian

☐ **CHANGE MARITAL STATUS** — **From:** ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed — **To:** ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ **NAME CHANGE** — ☐ Employee Name ☐ Dependent's Name ______
☐ By marriage ☐ Other, describe ______
Change Name to ______

☐ **CHANGE ADDRESS** — New Address ______

☐ **DELETE COVERAGE**
☐ Delete Spouse Name ______ As of ______
☐ Delete Child(ren) Name ______ As of ______
☐ Delete Employee Name ______ As of ______

☐ **TYPE OF COVERAGE TO BE DELETED**
☐ Delete All Coverage As of ***(indicate last day of work)*** ______
☐ Delete Medical As of ______
☐ Delete Dental As of ______
☐ Delete Vision/Other As of ______

WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within the time period required by your plan (30 or 31 days - see plan document) after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within the time limit allowed by your plan after the date of the marriage, birth, adoption, or placement for adoption. Your plan may also allow additional enrollment periods as specified in the plan document. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described, if you fail to enroll at this time you may not be eligible to enroll thereafter, or may be subject to certain restrictions which are described in your plan.

I waive coverage for:

- ❒ All Medical Coverage
- ❒ All Dental Coverage
- ❒ All Vision Coverage
- ❒ All Coverage
- ❒ All Dependent Medical Coverage
- ❒ All Dependent Dental Coverage
- ❒ All Dependent Vision Coverage
- ❒ All Dependent Coverage

Employee Signature______________________________ **Date**______________

Are you waiving the coverage listed above because you and/or your dependents have other health coverage? ❒ Yes ❒ No

With whom? ____

READ THIS STATEMENT AND AUTHORIZATION CAREFULLY

I hereby request coverage and authorize that any requested contribution for the coverage to which I may be entitled be deducted from my earnings. I am eligible for coverage and am working at least the number of hours per week required by my Employer. I understand that any failure to comply with the Utilization Review procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide CEBCO or its legal representative any information in its possession which is relevant to this application for coverage regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be used by employees, agents and business associates of CEBCO with responsibility for (1) reviewing applications and determining eligibility for coverage, (2) process and/or payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers, stop loss carriers, disease management service and/or wellness benefit providers, and other business associates who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). I understand that information disclosed to individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect until the date such coverage is terminated. (You, or any individual authorized by law to act on your behalf, have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, CEBCO will be unable to process my application for coverage. I understand that I have the right to revoke this authorization by submitting such revocation to CEBCO's Chief Privacy Officer at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage for me and my Dependent(s), if any.

Employee Signature ______________________________ Date ______________