

Wright State University Health Care Enrollment/Change Form

Directions:

To enroll for health coverages for yourself or yourself and your dependent(s), complete Sections 1 through 7 of this form. This Enrollment Form supersedes any previous health care enrollment as an employee of Wright State University. Use extra sheets of paper if necessary to list all covered dependents.

To change medical plan coverage, complete Sections 1 through 7 of this form.

To waive health coverages for yourself and your dependents, mark "Waiver of Health Coverage" in Section 1, complete the requested information in the first line of Section 4 and sign the form in Section 7.

To add coverage for one or more dependents, mark "Adding Dependent(s)" in section 1 and complete Sections 2 through 7. Please indicate the reason for the addition of coverage (e.g. Open Enrollment, marriage, birth, etc.) in the Coverage Status Change section of Section 5 for each dependent added.

To cancel coverage for one or more dependents, mark "Dropping Dependent(s)" in Section 1 and complete Sections 2 through 7. Please indicate the reason for the cancellation of coverage (e.g. divorce, no longer dependent child, etc.) in the Coverage Status Change section of Section 5.

1. Reason for Enrollment/Change Form <input type="checkbox"/> New Hire Enrollment <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Waiver of Health Coverages <input type="checkbox"/> COBRA Enrollment Effective Date for this Enrollment/Change:		2. Type of Medical, Prescription, Dental & Vision Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & 1 Dependent <input type="checkbox"/> Employee & 2 or More Dependents		3. Medical Plan Selected <input type="checkbox"/> Anthem Blue Preferred Primary HMO <input type="checkbox"/> Anthem Blue Access PPO <input type="checkbox"/> Anthem Blue Traditional <input type="checkbox"/> Anthem Lumenos Blue Access HDHP PPO			
4. Employee Information * Only complete Primary Care Physician (PCP) information if enrolling in the Anthem Blue Preferred Primary HMO medical plan.							
Last Name		First Name, Middle Initial		Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Social Security Number
Home Address			City	State	Zip code	Home Telephone	
Are you: Retired?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Full Time Hire Date		Hours Working Per Week		
Are you: Disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you: Hospitalized?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Anthem Blue Preferred Primary PCP Name*		Anthem Blue Preferred Primary PCP ID Number*		Are you a new patient with this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Family Information * Only complete Primary Care Physician (PCP) information if enrolling in the Anthem Blue Preferred Primary HMO medical plan.							
a. Coverage Status Change <input type="checkbox"/> Add <input type="checkbox"/> Drop Reason for change:	Last Name	First Name, Middle Initial	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
If other than the employee's spouse, is this individual eligible to be claimed as a federal tax exemption of the employee or employee's spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is health coverage for this individual required by a court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include legal documentation.		Is this individual currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide cause of hospitalization or disability.			
Dependent Social Security Number **REQUIRED**		Anthem Blue Preferred Primary PCP Name & ID Number*		Is this individual a new patient with this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Coverage Status Change <input type="checkbox"/> Add <input type="checkbox"/> Drop Reason for change:	Last Name	First Name, Middle Initial	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
If other than the employee's spouse, is this individual eligible to be claimed as a federal tax exemption of the employee or employee's spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is health coverage for this individual required by a court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include legal documentation.		Is this individual currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide cause of hospitalization or disability.			
Dependent Social Security Number **REQUIRED**		Anthem Blue Preferred Primary PCP Name & ID Number*		Is this individual a new patient with this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
c. Coverage Status Change <input type="checkbox"/> Add <input type="checkbox"/> Drop Reason for change:	Last Name	First Name, Middle Initial	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
If other than the employee's spouse, is this individual eligible to be claimed as a federal tax exemption of the employee or employee's spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is health coverage for this individual required by a court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include legal documentation.		Is this individual currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide cause of hospitalization or disability.			
Dependent Social Security Number **REQUIRED**		Anthem Blue Preferred Primary PCP Name & ID Number*		Is this individual a new patient with this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			

6. Other Health Coverage					
On the day your health coverage begins through Wright State University, list those family members (including those not listed on the previous page) who will be covered by any other medical, dental or vision coverage.					
List the name, phone number, and address of each of the other insurance companies or carriers providing coverage for your family member(s). Include policy ID #.					
Policy/Certificate holder's Name	Social Security # of Policyholder	Effective start date of Policy **REQUIRED**	Effective end date of Policy	Date of Birth of Policy Holder	Relationship of Policyholder to WSU employee:
If you and/or your dependents are enrolled in Medicare Part A or Part B or Medicaid, complete the following:					
Enrollee's Name(s)	Medicare/Medicaid #	Medicare Part A Effective Date	Medicare Part B Effective Date	End Stage Renal Disease Onset Date (if applicable)	
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> ESRD and Disability					

Please read this Authorization section carefully before signing this Health Care Enrollment/Change Form.

On behalf of myself and anyone enrolled on this Health Care Enrollment/Change Form ("Us"), I authorize any health care professional or entity to disclose to Anthem Blue Cross and Blue Shield, Express Scripts Inc., Delta Dental Plan of Ohio, and/or Vision Service Plan and any of their designees any and all records or information pertaining to medical, dental, prescription or vision history rendered to Us for any administrative service, including enrollment, payment of claims, utilization review, coordination of benefits, subrogation, health promotion, disease management and prevention programs. I authorize deduction from my wages of the required employee contribution for the coverages for which I, or any dependents, have applied. If applying for Anthem Blue Preferred Primary HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem Blue Cross and Blue Shield within 72 hours of signing this Enrollment/Change Form.

I understand that I am responsible to timely notify Wright State University of any change that would make me or any of my dependents ineligible for coverage.

I understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I acknowledge that I have read the conditions listed herein and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this Enrollment/Change Form are true and accurate to the best of my knowledge and I understand that they are being relied on by the various insurers in accepting this application. Any material misrepresentation or significant omission found in the completion of this Health Care Enrollment/Change Form may result in denial of benefits or rescission or cancellation of my coverage(s).

7. Review the entire Health Care Enrollment/Change Form for errors or omission and read the authorization language above before signing.	
By signing this, I am indicating that I have read and understand the language in the Authorization section of this Health Care Enrollment/Change Form and that I agree to its terms.	
Applicant's Signature	Date

Group Use: Group Name		Carrier	Sub-group #	Plan ID	Requested Effective Date
Wright State University		<input type="checkbox"/> Anthem	<input type="checkbox"/> 0000 <input type="checkbox"/> 0003 <input type="checkbox"/> 0006 <input type="checkbox"/> 0001 <input type="checkbox"/> 0004 <input type="checkbox"/> 0002 <input type="checkbox"/> 0005	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Date Medical Entered:	Date RX Entered:	Date Dental Entered:	Date Vision Entered:	Date HR System Entered:	