WRIGHT STATE UNIVERSITY

Health Care Enrollment/Change Form

Bargaining Unit Faculty
(Tenure and Non-Tenure Track Faculty)

Human Resources
115 Medical Sciences Building
3640 Colonel Glenn Hwy.
Dayton, OH 45435-0001
Tel: (937) 775-2120 Fax: (937) 775-3040

Section 1: Reason for Enrollment/Change Form

☐ New Hire Enrollment	☐ Adding Dependent(s)	☐ Waiver of Coverage	**Effective Date:**
☐ Annual Open Enrollment	☐ Dropping Dependent(s)	☐ Life Event: _____	

Section 2: Employee Information

Last Name:	**First Name, Middle Initial:**	**University ID:**	**Social Security Number:**
Home Address:	**City:**	**State:**	**Zip Code:**

Gender: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married	**Date of Birth:**	**Daytime Phone:**	**Department:**

Section 3: Health Care Elections

a. Coverage Election:	b. Type of Medical, Dental, & Vision Coverage:	c. Medical Plan Selection:
☐ Waive Medical, Dental, & Vision Coverage	☐ Employee Only	☐ Anthem PPO – 90/10
☐ Elect Medical, Dental, & Vision Coverage	☐ Employee & 1 Dependent	☐ Anthem PPO – 80/20
	☐ Employee & 2 or More Dependents	☐ Anthem Lumenos Blue Access HDHP

Section 4: Dependent(s) Information – If additional space is needed, please use a second sheet.

Dependent 1:	Dependent 2:	Dependent 3:	Dependent 4:
Last Name:	**Last Name:**	**Last Name:**	**Last Name:**
First Name, MI:	**First Name, MI:**	**First Name, MI:**	**First Name, MI:**
Relationship:	**Relationship:**	**Relationship:**	**Relationship:**
Social Security Number (Required):	**Social Security Number (Required):**	**Social Security Number (Required):**	**Social Security Number (Required):**
Date of Birth:	**Date of Birth:**	**Date of Birth:**	**Date of Birth:**
Gender: ☐ Male ☐ Female	**Gender:** ☐ Male ☐ Female	**Gender:** ☐ Male ☐ Female	**Gender:** ☐ Male ☐ Female
Currently hospitalized or disabled? ☐ Yes ☐ No	**Currently hospitalized or disabled?** ☐ Yes ☐ No	**Currently hospitalized or disabled?** ☐ Yes ☐ No	**Currently hospitalized or disabled?** ☐ Yes ☐ No

Continued onto next page.

Section 5: Other Health Coverage

On the day your health coverage begins through Wright State University, list those family members 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 number.		
Policy/Certificate Holder's Name:	**SSN of Policy Holder:**	**Date of Birth of Policy Holder:**
Relationship to WSU Employee:	**Effective Start Date of Policy:**	**Effective End Date of Policy:**

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 Number:**	**Medicare Part A Effective Date:** _____ **Medicare Part B Effective Date:** _____
Enrollee's Name(s):	**Medicare/Medicaid Number:**	**Medicare Part A Effective Date:** _____ **Medicare Part B Effective Date:** _____

Reason for Medicare Entitlement: ☐ **Age** ☐ **Disability** ☐ **End Stage Renal Disease (ESRD), Onset Date:** _____ ☐ **ESRD & 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.

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).

Section 6: 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 understood the language in the Authorization section of this Health Care Enrollment/Change Form and that I agree to its terms.

Applicant's Signature:	**Date:**

Employer Use Only

Effective Date:	☐ **ANT**	**Subgroup:**		**Health Plan ID:**			**Update:**	☐ **DD**	☐ **VSP**
	☐ EE Only	☐ 0000 - BUFAC	☐ 0003 - UNC	☐ 1	☐ 6	☐ 10	☐ PDABENE	☐ EE Only	☐ EE Only
HR Analyst:	☐ EE + 1	☐ 0001 - OTHER FAC	☐ 0004 - PT	☐ 2	☐ 7		☐ PDABCOV	☐ EE + 1	☐ EE + 1
	☐ EE + 2<	☐ 0002 - CLS	☐ 0005 - NTE	☐ 5	☐ 9			☐ EE + 2<	☐ EE + 2<
☐ **ACCESS**	☐ **Banner**	☐ **HSA Adjustment:**		☐ **COBRA Notification**				☐ **Banner**	☐ **Banner**