WRIGHT STATE UNIVERSITY

Health Care Change Form

Human Resources
3640 Colonel Glenn Hwy.
University Hall, Suite 200
Dayton, OH 45435-0001
Tel: (937) 775-2120 Fax: (937) 775-3040

Section 1: Reason for Change Form

☐ Adding Dependent(s)	☐ Gained Coverage	☐ Death of a Dependent	Effective Date:
☐ Dropping Dependent(s)	☐ Loss of Other Coverage	☐ 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 for Employee – Must carry medical, dental, and/or vision for self in order to carry for dependents.

For my SELF, I choose to make the following elections:

a. Medical Plan Election:		b. Dental Plan Election:	c. Vision Plan Election:
☐ Waive Medical Coverage	☐ Blue High Performance Network (HPN)	☐ Waive Dental Coverage	☐ Waive Vision Coverage
☐ Elect Medical Coverage	☐ High Deductible Health Plan (HDHP)	☐ Elect Dental Coverage	☐ Elect Vision Coverage
	☐ PPO 80/20		

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

For my DEPENDENT(S), I choose to make the following elections:

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
For the dependent named above, I choose to make the following elections:	For the dependent named above, I choose to make the following elections:	For the dependent named above, I choose to make the following elections:	For the dependent named above, I choose to make the following elections:
Medical: ☐ Add ☐ Drop	Medical: ☐ Add ☐ Drop	Medical: ☐ Add ☐ Drop	Medical: ☐ Add ☐ Drop
Dental: ☐ Add ☐ Drop	Dental: ☐ Add ☐ Drop	Dental: ☐ Add ☐ Drop	Dental: ☐ Add ☐ Drop
Vision: ☐ Add ☐ Drop	Vision: ☐ Add ☐ Drop	Vision: ☐ Add ☐ Drop	Vision: ☐ Add ☐ Drop

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 outside of the Open Enrollment period, I can make changes within 31 days of experiencing a qualifying life event, such as birth, marriage, divorce, loss in other healthcare coverage, etc.

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:**	**Update:**	**DD**	**VSP**
HR Analyst:	☐ EE Only ☐ EE + CH ☐ EE + SP ☐ Family	☐ NBUF ☐ CLS ☐ UNC ☐ ACA	☐ PPO 80/20 ☐ **HDHP** ☐ Blue HPN	☐ PDABENE ☐ PDABCOV	☐ EE Only ☐ EE + CH ☐ EE + SP ☐ Family	☐ EE Only ☐ EE + CH ☐ EE + SP ☐ Family
	☐ **Banner**	☐ **HSA Adjustment**	☐ **COBRA Notification**		☐ **Banner**	☐ **Banner**

Benefits Team: _____ **Qualtrics Tobacco Affidavit: Yes No**