

GREENE COUNTY

HEALTH CARE ENROLLMENT APPLICATION

Fax: (866) 391-7446 / (812) 373-8717 FOR EMPLOYER HR USE ONLY ID#: Plan Choice: Subgroup / Location: **EMPLOYEES MUST COMPLETE SECTIONS** Approval: Effective Date: A through D. PLEASE PRINT ALL INFORMATION. Sect. A Last Name M.I. Social Security Number First About You (REQUIRED) Street Address (Home) City State Zip Code □F Sex: ΠM Birth Date (Month/Day/Year) Telephone: Day Evening Hire Date Marital Status (Single/Married/Divorced/Separated) Employee Email Address: EOB preference (Please choose one): ☐ Email Notification or ☐ Print Apply to all under 18 dependents ☐ Yes ☐ No Sect. B Coverage □ Employee Medical & RX: ☐ Employee & Spouse ☐ Employee & Children ☐ Family Options Vision: □ Employee ☐ Employee & Spouse ☐ Employee & Children □ Family Sect. C Place a ✓ for coverage selection. Please complete the section below only for each person to be covered. Birthday Relation to Employee Sex M/F Disabled Last First MI Mo./Day/Year Security Natural Child Other Step Dep. (Specify Last Name if different) Number **About Your Dependents** 02 Spouse 03 Child (if applicable) 04 Child 05 Child 06 Child For additional children, please attach a separate page. Be sure to include the information requested above. For adult dependents age 18 and older please fill out the second page of this enrollment form. Sec D Is your spouse employed? ☐ Yes ☐ No Is medical, dental or vision coverage available? ☐ Yes ☐ No Is any member of your family covered under your spouse's plan or any other health insurance plan? ☐ Yes ☐ No *If you answered yes to the above question it is required that you fill out page 3 of this form. OVER -

NOTE: Please attach a Certificate of Creditable Coverage for yourself and/or your dependents if you have been previously covered under another group health plan.

OVER ──

Benefits to Add:	☐ Medical		/ision			
Reason to add : _		Ex	camples: Loss of c	ther coverage, Marria	ge, Birth, Adoptio	n, Custody or Legal
Guardianship, etc						
Full	Name	Sex M/F	Birth Date (MM/DD/YY)	Social Security Number	Relation to Employee	Date for insurance to be effective
Please provide phys	ical residence addre	ess if othe	er than your physica	al address:		
Street Address (Ho	ome)		City	State	Zip Code	
Is this dependent en	nployed? □ Yes □	No If y	es, is insurance co	verage available throu	gh employer? □ Y o	es □ No
· ·	• •	-		Date of		
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COORDINATION OF BENEFITS QUESTIONS OTHER COVERAGE INFORMATION Please complete this section if other coverage is provided through your spouse. Place of Employment: Address: Name of insurance Co: Address: Phone: Policy ID Number: Effective date: About Your Is the subscriber: ☐ Full Time ☐ Self Employed ☐ Retired, if so Date of Retirement: Spouse (if applicable) Type of Coverage: ☐ Medical/RX ☐ Dental ☐ Vision Is this Plan: ☐ Active ☐ Retiree ☐ COBRA Please list Covered Members: Spouse:______ Date Of Birth: _____ Child: Child: Child: Child: Please complete this section if other coverage is provided through Medicare. Medicare Are you or your spouse eligible for Medicare: ☐ Yes ☐ No Coverage Part A effective date: Part B effective date: (if applicable) Reason for Medicare Coverage: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease, Date Dialysis Began: Please complete if other coverage is provided through a former spouse. Place of Employment: _____ Address: _____ About Name of insurance Co: Address: Your Policy/Group Number: Effective date: **Former** Spouse Is the subscriber: ☐ Full Time ☐ Self Employed ☐ Retired, if so Date of Retirement: (if applicable) Type of Coverage: ☐ Medical/RX ☐ Dental ☐ Vision Is this Plan: ☐ Active ☐ Retiree ☐ COBRA Please list Covered Members Former Spouse: Date Of Birth: Child: Child: Child: **AUTHORIZATION/DECLINATION OF COVERAGE** Please select one of the following options and sign below. Authorization I authorize hospitals, physicians or other providers of service to furnish SIHO (acting as the TPA for my employer), upon request, any and all reports and records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents under age 18 after this date, together with like reports and records or copies thereof of earlier services for purposes of П processing this application and for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. In recognition of the legitimate interest of my employer in reviewing historical data setting forth the volume, nature and costs of healthcare services paid by my employer, I hereby authorize SIHO to provide my employer plan with information relating to medical services and treatment rendered to me and/or my dependents under age 18 listed on this application. I, for myself and for those of my eligible dependents listed above, hereby agree to abide by the rules, regulations and terms of my employer's group health plan documents as such documents may be amended. I shall cooperate and assist SIHO in the exercise of the subrogation and coordination of benefits rights of my employer's plan. I certify that the information furnished is true and complete to the best of my knowledge. Declination I am declining enrollment for myself and dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption. or placement for adoption. **Employee Signature** Print Name Date