ONONDAGA COUNTY EMPLOYEE BENEFITS ENROLLMENT

EMPLOYER SECTION

GROUP NO.	DEPT./PKG. NO.	DIV./PKG.NO.	UNION CODE	EMPLOYEE KEY NO. (INCLUDE S.S.NO.)	
ORIG. EMPLOYMENT DATE	TERMINATION DATE	RETIREMENT DATE	REINSTATEMENT DATE	POSITION JOB TITLE	LINE NUMBER

CHECK (✓) ONE: ☐101 ☐103	☐ ACTIVE/FULL TIME ☐ ACTIVE/PART TIME	DATE STATUS EFFECTIVE	IF PART TIME, NO. HRS. WORKED PER P.P.

CHECK (✓) ONE: ☐ NEW HIRE ☐ LEAVE OF ABSENCE ☐ DECEASED ☐ TERMINATION ☐ COBRA ☐ RETIRED ☐ DISABLED ☐ SURVIVOR ☐ ADD/CHANGE (DESCRIBE BELOW)

INSTRUCTIONS: ALL APPROPRIATE AREAS MUST BE COMPLETED AND THE FORM SIGNED

EMPLOYEE INFO.

SOCIAL SECURITY NO.	EMPLOYEE LAST NAME	FIRST NAME	INITIAL
STREET ADDRESS	CITY	STATE	ZIP

MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ LEGALLY SEPARATED	DATE OF MARRIAGE	BIRTHDATE HOME PHONE	SEX, M-F WORK PHONE
PCP CHOICE	ESTABLISHED PAT. ☐ YES ☐ NO	ARE YOU PRESENTLY EMPLOYED ELSEWHERE? ☐ YES ☐ NO	ARE YOU RETIRED? ☐ YES ☐ NO

NAME OF OTHER OR PREVIOUS EMPLOYER

DO YOU HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE THRU YOUR OTHER OR PREVIOUS EMPLOYER? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

TYPE OF BENEFITS				
HEALTH ☐	NAME OF CARRIER/MEDICARE HIC NO.	MEDICARE A EFF. DATE MEDICARE B EFF.DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL ☐ FAMILY ☐
DENTAL ☐	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL ☐ FAMILY ☐

SPOUSE INFO.

LAST NAME **SUPPLY MARRIAGE CERTIFICATE ■VERIFIED**	FIRST NAME	INITIAL	SPOUSE SOCIAL SECURITY NO.

BIRTHDATE	SEX, M-F	EMPLOYED	DISABLED	DATE DISABLED	MEDICARE	MEDICARE HIC NO.
		☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO	

PCP CHOICE	ESTABLISHED PAT. ☐ YES ☐ NO	DOES YOUR SPOUSE HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE? ☐ YES ☐ NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE

TYPE OF BENEFITS				
HEALTH ☐	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL ☐ FAMILY ☐
DENTAL ☐	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE INDIVIDUAL ☐ FAMILY ☐

DEPENDENT INFO.

IF A DEPENDENT IS OVER AGE 18, A STUDENT DEPENDENT CERTIFICATION MUST BE COMPLETED (SUPPLY BIRTH CERTIFICATE) ■VERIFIED

LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED	DATE DISABLED	MEDICARE
						☐ YES ☐ NO		☐ YES ☐ NO

DEPENDENT SOC. SEC. NO.	EMPLOYED	COLLEGE FULL TIME	PCP CHOICE	ESTABLISHED PAT.	
	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE

LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED	DATE DISABLED	MEDICARE
						☐ YES ☐ NO		☐ YES ☐ NO

DEPENDENT SOC. SEC. NO.	EMPLOYED	COLLEGE FULL TIME	PCP CHOICE	ESTABLISHED PAT.	
	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE

LAST NAME (IF DIFFERENT)	FIRST NAME	INITIAL	BIRTHDATE	SEX, M-F	RELATIONSHIP	DISABLED	DATE DISABLED	MEDICARE
						☐ YES ☐ NO		☐ YES ☐ NO

DEPENDENT SOC. SEC. NO.	EMPLOYED	COLLEGE FULL TIME	PCP CHOICE	ESTABLISHED PAT.	
	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO	MEDICARE A EFF. DATE MEDICARE B EFF. DATE

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, PLEASE USE ANOTHER FORM, BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER ON ANY ADDITIONAL FORMS.

BENEFITS

TYPE	OPTION	COVERAGE	COVERAGE	EFFECTIVE DATE	CANCELLATION DATE	CODE
HEALTH ☐ YES ☐ NO	ONONDAGA CO. ☐ HMO ☐ ________ NAME OF HMO	INDIVIDUAL ☐ FAMILY ☐				
DENTAL ☐ YES ☐ NO	ONONDAGA CO. DENTAL PLAN ☐	INDIVIDUAL ☐ FAMILY ☐				

DATE: ____________ SIGNATURE ______________________________ DATE: ____________ EMPLOYER'S REPRESENTATIVE ____________

RELEASE • I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents). • I hereby accept responsibility for payment of any portion of the premium and authorize my employer to make the required deductions. • I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information. I understand that the OnPoint coverage is comprised of the POS in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provides the highest level of coverage.

DESCRIBE ADD/CHANGE:

RELEASE - You must sign and date this form to be eligible for insurance.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

White Copy - Vendor • Yellow Copy - File • Pink Copy - Duplicate