Employee Benefits Enrollment Form

PHONE: 800•229•2210
FAX: 440•349•4268
5910 HARPER ROAD
CLEVELAND, OHIO
44139-1835

Applicant Information (Employee)

Name of Employer	Group Number	Division	Effective Date
COALITION OF PUBLIC SAFETY EMPLOYEES HEALTH TRUST	**000071792**		

Your Name (first, initial, last)	Social Security Number	Date of Birth	☐ Male ☐ Female

Mailing Address	City, State, Zip Code

Date of Hire	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Phone	Email Address

Type of Enrollment

Select Desired Coverage

Major Medical	**Dental**	**Vision**
Employee	Employee	Employee
Spouse	Spouse	Spouse
Child(ren)	Child(ren)	Child(ren)

Change Request

☐ New Hire ☐ Transfer ☐ Adoption
☐ Marriage ☐ Divorce ☐ Birth
☐ Death ☐ Add Dependent ☐ Delete Dependent
☐ Involuntary loss of coverage ☐ Court order (copy required)

Date event occurred:_______/______/_________

Dependent Name	Gender	Date of Birth	Social Security Number
Spouse:	☐M ☐F		
Child 1:	☐M ☐F		
Child 2:	☐M ☐F		
Child 3:	☐M ☐F		
Child 4:	☐M ☐F		

Please list dependent(s) address if different from address of employee. Dependent(s) ________________________ Address: ______________________________________

Current Coverage Information (Please complete for proper coordination of benefits administration)

Is any person listed on this application now covered by any other health insurance, including Medicare or Medicaid? ☐ Yes ☐ No
If **YES**, please complete all information below for **each** person listed on this application. If Medicare, date of entitlement Part A: ______ Part B: ______ Reason: ___________

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Start Date (mm/dd/yy)	Will Policy Continue?
Employee:					Yes No
Spouse:					Yes No
Child(ren) :					Yes No

Waiver (This section must be completed if declining to enroll)

This is to acknowledge that I have been given the opportunity to apply for the above group coverage(s) available to me and my dependents.

I hereby waive coverage for:

☐ Myself	Medical	Dental	Vision
☐ My Spouse	Medical	Dental	Vision
☐ Dependent Child(ren)	Medical	Dental	Vision

I decline to apply for other coverage because:
☐ Spousal coverage ☐Medicare Supplement ☐Individual Health Insurance
☐ Other _________________ If you are declining medical coverage for yourself or dependents because of other coverage, you may in the future be able to enroll yourself or your dependents in the medical plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after a marriage, birth, adoption or placement for adoption.

PROTECTED HEALTH INFORMATION RELEASE

Upon presentation of the original or a photocopy of this signed Release, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Blue Water Benefits Administrators or an agent, attorney, consumer reporting agency or independent administrator or medical review consultants, acting on its behalf, Protected Health Information concerning advice, care, treatment, proposed care or treatment, or pre-certification of care provided to the insured named below or the spouse or children thereof. This may include information relating to mental illness, use of drugs or alcohol. I also authorize any employer, group policy holder or benefit plan administrator to provide Blue Water Benefits Administrators with financial or employment related information.

I understand that the information authorized herein will be used by Blue Water Benefits Administrators to evaluate a claim for insurance benefits and that I or any authorized representative will receive a copy of this Release upon request. Information obtained will not be released to any person or organization EXCEPT to re-insuring companies, or other persons or organizations performing business or legal service in connection with the claim.

I understand that I have the right to revoke this Release to prevent disclosures of Protected Health Information following our receipt of your revocation. To revoke this Release, please send a signed request stating your intent to revoke, along with a copy of your Release to Blue Water Benefits Administrators at the address listed below. This authorization is valid from the date signed for the duration of the claim.

Please note that while all efforts at maintaining confidentiality will be taken, the Protected Health Information used or disclosed pursuant to the Release may be subject to re-disclosure by the recipient and therefore may no longer be protected. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing false or deceptive statement is guilty of insurance fraud. If applicable, I authorize my employer to deduct from my wages the required contribution for coverage. The information provided on this form is true and complete to the best of my knowledge.

Employee Signature ____ **Date** ________________________________ **BWBA Use** _________