City of Toledo
DEPARTMENT OF HUMAN RESOURCES

Health Benefits Application and Change Form

☐NEW ENROLLEE ☐ REINSTATEMENT ☐POLICY CHANGE

DATE OF HIRE: _____ DATE OF QUALIFYING EVENT: _____ EFFECTIVE DATE OF COVERAGE: _____

CHANGES:	ADD DEPENDENTS DUE TO:	DROP DEPENDENTS DUE TO:
☐CHANGE OF NAME	☐MARRIAGE	☐DEATH
☐ADDRESS CHANGE	☐DOMESTIC PARTNER	☐DIVORCE
☐OTHER_____	☐BIRTH/ADOPTION	☐DOMESTIC PARTNER TERMINATION
	☐AFFORDABLE HEALTHCARE ACT	☐NO LONGER ELIGIBLE
	☐OTHER_____	☐OTHER_____

EMPLOYEE INFORMATION:

Last Name	First Name	MI	Gender	Birth Date	Social Security Number

Address	City	State	Zip Code	Daytime Phone#

Union Affiliation	Job Title	Dept/Division	Location Code#

DEPENDENT INFORMATION:

RELATIONSHIP STATUS: ☐SINGLE ☐MARRIED ☐DOMESTIC PARTNERSHIP ☐DIVORCED ☐DOMESTIC PARTNERSHIP TERMINATION ☐ WIDOWED

EFFECTIVE DATE OF RELATIONSHIP STATUS: _____

IS YOUR SPOUSE OR DOMESTIC PARTNER EMPLOYED OR RETIRED? ☐NO ☐ YES, PLEASE PROVIDE NAME OF EMPLOYER _____

IF YOU NAME A CHILDBELOW, IS THERE A COURT ORDER SAYING WHICH PERSON IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE BENEFITS?

☐NO ☐YES, PRINT NAME OF RESPONSIBLE PERSON AND RELATIONSHIP TO THE EMPLOYEE: _____

Relationship to Employee	First name	MI	Last name	Gender	Birth Date	Social Security Number	Coverage Level
Spouse/Domestic Partner				M / F			☐PRIMARY ☐SECONDARY
Child/Dependent				M / F			☐PRIMARY ☐SECONDARY
Child/Dependent				M / F			☐PRIMARY ☐SECONDARY
Child/Dependent				M / F			☐PRIMARY ☐SECONDARY
Child/Dependent				M / F			☐PRIMARY ☐SECONDARY

WHEN ADDING A SPOUSE OR OTHER DEPENDENT YOU MUST ATTACH REQUIRED DOCUMENTS SHOWING THE DEPENDENT STATUS OF EACH PERSON WHO WILL BE COVERED BY YOUR INSURANCE. THESE DOCUMENTS MAY INCLUDE: A COPY OF THE FIRST PAGE OF YOUR MOST RECENT FEDERAL TAX RETURN (WITH ALL FINANCIAL INFORMATION DELETED), MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, CHILD SUPPORT ORDER, DIVORCE DECREE, DOMESTIC PARTNERSHIP DECLERATION, DOMESTIC PARTNER TERMINATION NOTICE, ETC.

over

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OTHER HEALTH CARE COVERAGE:

IS YOUR SPOUSE/DOMESTIC PARTNER AND/OR ANY OTHER DEPENDENT COVERED BY OTHER HEALTH CARE BENEFITS? ☐NO ☐YES, PROVIDE THE FOLLOWING INFORMATION:

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Employee: _____ Effective Date of Coverage: _____

Policy Holder's Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

List Covered Dependents: _____ _____

_____ _____

_____ _____

I HEREBY APPLY FOR THE COVERAGE INDICATED ABOVE. I AUTHORIZE ANY MEDICAL PROFESSIONAL, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, GOVERNMENT AGENCY, OR OTHER PERSON TO PROVIDE THE CITY OF TOLEDO PLAN ADMINISTRATOR INFORMATION INCLUDING COPIES OF RECORDS CONCERNING ADVICE, CARE OR TREATMENT PROVIDED TO ME AND/OR MY DEPENDENTS INCLUDING, WITHOUT LIMITATION, INFORMATION RELATED TO MENTAL ILLNESS OR USE OF DRUGS OR ALCOHOL. I UNDERSTAND THAT THE COVERAGE FOR WHICH I AM APPLYING FOR CONTAINS COORDINATION OF BENEFITS, WORKERS' COMPENSATION, AND SUBROGATION PROVISIONS AND ACKNOWLEDGE THE CITY OF TOLEDO PLAN ADMINISTRATOR'S RIGHT TO ENFORCE THESE PROVISIONS.

I UNDERSTAND THAT ANY FALSE DECLARATION, MATERIAL OMISSION OF INFORMATION, MISREPRESENTATION OR FALSIFICATION ON ENROLLMENT APPLICATIONS AND ANY AND ALL DOCUMENTS RELATED TO AND SUBMITTED FOR CITY OF TOLEDO BENEFITS COVERAGE MAY CONSTITUTE FRAUD AND MAY RESULT IN THE LOSS OF BENEFITS, LOSS OF COBRA CONTINUATION COVERAGE AND/OR LOSS OF DOMESTIC PARTNER CONTINUATION COVERAGE FOR MYSELF, ANY SPOUSE, DOMESTIC PARTNER, CHILDREN OR OTHER DEPENDENTS, MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING, TERMINATION OF EMPLOYMENT UNDER CITY OF TOLEDO POLICY, APPLICABLE LAW AND/OR COLLECTIVE BARGAINING AGREEMENT AND MAY RESULT IN THE CITY OF TOLEDO PURSUING CRIMINAL CHARGES AGAINST ME. I AGREE THAT THE CITY OF TOLEDO MAY RECOVER DAMAGES FOR ALL LOSSES INCLUDING, BUT NOT LIMITED TO, PAID CLAIMS, PREMIUM COSTS AND REASONABLE ATTORNEY FEES INCURRED.

I FURTHER UNDERSTAND THAT FAILURE TO INFORM THE DEPARTMENT OF HUMAN RESOURCES PLAN ADMINISTRATOR WITHIN 30 DAYS ABOUT ANY QUALIFYING EVENT OR ANY CHANGE IN CIRCUMSTANCES OR STATUS THAT WOULD MAKE MYSELF, ANY SPOUSE, DOMESTIC PARTNER, CHILDREN OR OTHER DEPENDENTS INELIGIBLE FOR COVERAGE UNDER THE TERMS OF CITY OF TOLEDO BENEFITS PLAN POLICY AND PROCEDURE MAY CONSTITUTE FRAUD AND MAY RESULT IN THE LOSS OF BENEFITS, LOSS OF COBRA CONTINUATION COVERAGE AND/OR LOSS OF DOMESTIC PARTNER CONTINUATION COVERAGE FOR MYSELF, ANY SPOUSE, DOMESTIC PARTNER, CHILDREN OR OTHER DEPENDENTS AND MAY RESULT IN THE CITY OF TOLEDO PURSUING DISCINPLINARY AND/OR CRIMINAL CHARGES AGAINST ME.

I CERTIFY THAT THE INFORMATION PROVIDED IN ALL PARTS OF THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE.

APPLICANT SIGNATURE: _____ DATE: _____

Any person who, with intent to defraud or knowing that he 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. (ORC 3999.21)

I HEREBY WAIVE COVERAGE UNDER THE HEALTH INSURANCE PROGRAM:

☐FOR MYSELF ☐FOR MYSELF AND FAMILY MEMBERS ☐FOR FAMILY MEMBERS ONLY ☐FOR ONLY THE FOLLOWING: _____

APPLICANT SIGNATURE: _____ DATE: _____

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