Lake Erie Regional Council

1885 Lake Avenue, Elyria, Ohio 44035 Phone: 440-324-5777 Fax: 440-324-4485

INSURANCE ENROLLMENT FORM

EMPLOYEE INFORMATION			
FULL NAME		BIRTH DATE	
ADDRESS CITY, ZIP CODE		PHONE	
SOCIAL SECURITY		SEX	

MARRIED _____ MARRIAGE DATE:_____ SINGLE_____ DIVORCED_____ WIDOWED_____

COVERAGE INFORMATION				TO BE COMPLETED BY DISTRICT OFFICE	
PLAN	SINGLE	FAMILY	DECLINE	SCHOOLDISTRICT	SHEFFIELD/SHEFFIELD LAKE LOCAL SCHOOLS
PREMIUM				DATE OF HIRE	
MINIMUM VALUE HIGH DEDUCTIBLE PLAN				EFFECTIVE DATE	
DENTAL				DEPARTMENT	ADMINISTRATIVE CERTIFIED CLASSIFIED
VISION ADMINISTRATIVE					
VISION CERTIFIED/CLASSIFIED					

I would like to cover the following dependents:

DEPENDENT	LAST NAME	FIRST NAME	DOB	SEX	SS#
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					

Are you or any dependent on **Medicare**? YES_____ NO____
Medicare Policyholder Name: _____

If you and/or your spouse are on Medicare but have coverage through LERC, your group health plan is primary and Medicare is secondary.

EMPLOYEE SIGNATURE

_____ **DATE**_____
By signing I agree that I received a HIPAA Notice of Special Enrollment Rights Statement

TREASURER/DESIGNEE SIGNATURE

_____ **DATE**_____

Please review your HIPAA Notice of Special Enrollment Rights on page two.

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HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days" or any longer period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.

Lake Erie Regional Council Employee Protection Plan

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OTHER INSURANCE COVERAGE

Complete this form if your spouse/dependents have other coverage including other LERC Plans.

EMPLOYEE INFORMATION			
FULL NAME		SOCIAL SECURITY	

I or other family members have other insurance.
(This includes coverage with another LERC School District or any other plan)
CLAIMS WILL NOT BE PAID IF YOU DO NOT CONFIRM OR DENY OTHER INSURANCE FOR YOUR DEPENDENTS

OTHER CARRIER INFORMATION	
INSURANCE CARRIER	
EMPLOYER	
NAME OF INSURED	
EFFECTIVE DATE	
CANCELLED DATE	
FAMILY PLAN ☐	SINGLE ONLY ☐

LIST INDIVIDUALS COVERED UNDER THE OTHER PLAN AND SELECT PLAN COVERAGE (Medical/Dental/Vision/Prescription)

DEPENDENT	LAST NAME (if different)	FIRST NAME	NAME OF INSURANCE COMPANY/ID NUMBER	MED/RX	DENT	VIS
Self						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

EMPLOYEE SIGNATURE_____ DATE_____

TREASURER/DESIGNEE SIGNATURE_____ DATE_____