



**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	SSH#	
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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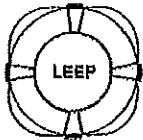
**HIPAA Notice of Special Enrollment Rights**

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

1885 Lake Avenue, Elyria, Ohio 44035

440-324-5777

Fax: 440-324-4485

## OTHER INSURANCE COVERAGE

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

### EMPLOYEE INFORMATION

FULL NAME		SOCIAL SECURITY	
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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 <input type="checkbox"/>	SINGLE ONLY <input type="checkbox"/>

### 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 \_\_\_\_\_