LAKE ERIE REGIONAL COUNCIL

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

INSURANCE ENROLLMENT FORM

FIRST NAME		LAST NAME		BIRTH DATE	

STREET ADDRESS		CITY		ZIP CODE	

SOCIAL SECURITY NO		DATE OF HIRE		EFFECTIVE DATE OF COVERAGE	

STATUS	SINGLE		MARRIED		MARRIAGE DATE		DIVORCED		WIDOWED		PHONE	

DISTRICT YOU WORK IN	WELLINGTON EXEMPTED VILLAGE SCHOOLS Please return completed form to theTreasurer's Office - Wellington Schools

MEDICAL PLANS	SINGLE	FAMIY	DECLINE	DENTAL PLANS	SINGLE	FAMIY	DECLINE
PREMIUM PLAN				DELTA DENTAL			
MINIMUM VALUE PLAN (High Deductible Plan)				VISION PLAN	SINGLE	FAMIY	DECLINE
DEPARTMENT CLASSIFICATION:	ADMIN		CERTIFIED		CLASSIFIED		

I would like to cover the following dependents:

DEPENDENT	LAST NAME	FIRST NAME	DOB	SEX	SS#	MED	DEN	VIS
SPOUSE								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								

Are you or any dependent on Medicare?	YES		NO		MEDICARE POLICYHOLDER	

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 note that birth certificates, marriage certificates and Social Security Cards should be kept on file.
When necessary, I may request a copy. Thank you

LERC

LAKE ERIE REGIONAL COUNCIL

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

OTHER INSURANCE COVERAGE

Complete this form EVEN if your spouse/dependents have no other coverage including other LERC Plans.

FIRST NAME		LAST NAME		SOCIAL SECURITY	

CLAIMS WILL NOT BE PAID IF YOU DO NOT CONFIRM OR DENY OTHER INSURANCE FOR YOUR DEPENDENTS

My dependents have no other coverage	YES		NO	

OTHER CARRIER INFORMATION	
INSURANCE CARRIER	
EMPLOYER	
NAME OF INSURED	
POLICY NUMBER	
EFFECTIVE DATE	
CANCELLED DATE	

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

DEPENDENT	LAST NAME (if different)	FIRST NAME	MED/RX	DENTAL	VISION	INSURANCE PROVIDER NAME
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

EMPLOYEE SIGNATURE		DATE	

LAKE ERIE REGIONAL COUNCIL

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

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.