The University of Toledo

HEALTHCARE Election Form: Medical/Rx, Dental, Vision

Rocket #

SECTION I: PERSONAL INFORMATION

Employee's Last Name　　First　　M.I.　　Date of Birth　　Social Security Number

Home Address　　City　　State　　Zip　　Home Phone Number　　Daytime Phone Number

SECTION II: REASON FOR COMPLETING FORM

Date of event: _____ / _____ / _____ (return form within 30 days of event date)

Qualifying status change (please specify)

- Hired/Newly Eligible
- Open Enrollment
- Other[1] (please describe): ______________________
- Birth/Adoption/Legal Guardianship[1]
- Marriage[1]
- Loss of Other Coverage[1]
- Addition of Domestic Partner Coverage[2]
- Addition of Dependent due to Eligibility[1]

[1]Documentation may be required.　　[2]Affidavit required.

SECTION III: HEALTH PLAN COVERAGE SELECTION

Please select: Main Campus Employee ______ HSC Employee ______

I elect Medical/Rx coverage -- make plan selection below

- OBA/FrontPath PPO **(Main Campus Only)**
- Paramount Healthcare ES
- Medical Mutual CDHP **(HSA Form must also be completed)**

I waive Medical/Rx coverage

I elect Dental coverage

I waive Dental coverage

I elect Vision coverage

I waive Vision coverage

For HR Office Use Only

E-Class ________　　F/T or P/T

	Deduction Code	PDADEDN	PDABCOV
Medical			
Rx			
Dental			
Vision			

SECTION IV-A: ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

(Please list all family members to show new coverage)

Name	Relationship to Employee (see below)	Date of Birth (M/D/Y)	Gender M	Gender F	Social Security Number	Address different from employee?* Yes	No	Medical/Rx Yes	No	Dental Yes	No	Vision Yes	No	For HR Office Use Only BENE	BCOV

If dependent's address differs from employee's address, provide dependent's address in **SECTION IV-C on back. Additional dependents may be added on back as well.*

Does anyone listed above have other coverage?　　NO　　YES, If yes please list on back under "Other Coverage"

Please use the following numbers and letters to indicate **Relationship to Employee**

1 Employee　　**2** Spouse　　**3** Dependent Child　　**4** Domestic Partner

3A Dependent Child of Employee
3B Dependent Child of Employee's Spouse
3C Dependent Child of Employee's Domestic Partner
NOTE: If Dependent Child is over the age of 19, a Dependent Verification Affidavit is required.

AUTHORIZATION

I hereby apply to The University of Toledo Healthcare Benefits Program for the coverage indicated above. I have read and understand the material explaining the terms and conditions of The University of Toledo Healthcare Plans. I declare that any individual for whom I am requesting healthcare coverage meets the definition of an eligible dependent. I understand that any person who knowingly and with intent to defraud applies for coverage or files a claim containing any materially false information is guilty of fraud and is thereby subject to disciplinary action, up to and including termination of benefits and/or employment as well as possible prosecution for insurance fraud. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year unless a qualifying status change occurs, as defined by the plan. The Benefits Office must receive notification on the appropriate form(s) within 30 days. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation and subrogation provisions, and I acknowledge The University of Toledo's right to enforce these provisions. I authorize The University of Toledo to deduct the required semi-monthly contribution from my pay on a pre-tax and/or after tax basis. I understand that The University of Toledo's contribution amount for coverage for Domestic Partner and his or her dependent(s) is considered imputed income and I will be taxed on that value. **I certify that all information provided on this form is true and correct to the best of my knowledge.**

Signature　　　　Date

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SECTION IV-B: ELIGIBLE DEPENDENT ENROLLMENT INFORMATION (cont'd)

Use the space below to record additional eligible dependent information as needed.

Name	Relationship to Employee	Date of Birth (M/D/Y)	Gender		Social Security Number	Address different from employee?*		Choose coverage for each eligible dependent: Medical/Rx		Dental		Vision		BENE	BCOV
			M	F		Yes	No	Yes	No	Yes	No	Yes	No		

If dependent's address differs from employee's address, provide dependent's address in SECTION IV-C below.

SECTION IV-C: DEPENDENT ADDRESS INFORMATION (if different from employee's address)

If you indicated in SECTION IV-A or IV-B that any dependent's address differs from the employee's address, please provide that dependent's name and mailing address below:

Dependent's Name

Street Address

City State Zip

Dependent's Name

Street Address

City State Zip

OTHER INSURANCE

Policy Holder Name Effective Date Policy Number

Insurance Company Family Members Covered

If you have questions, contact the Office of Human Resources Benefits Department at (419) 530-4747

Return completed form to: Office of Human Resources, Benefits Department, MS #205, 2801 W. Bancroft St., Toledo, OH 43606. Fax: (419) 530-1492