



THE UNIVERSITY OF TOLEDO 1872

Health Science Campus

HEALTHCARE Election Form: Medical, Rx, Dental, Vision

Rocket #

SECTION I: PERSONAL INFORMATION

Employee's Full Name First M.I. Last Social Security Number

Home Address 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 Birth/Adoption/Legal Guardianship¹ Loss of Other Coverage¹
- Open Enrollment Marriage¹ Addition of Domestic Partner Coverage²
- Other¹ (please describe): _____ Addition of Dependent due to Eligibility¹

¹Documentation may be required. ²Affadavit required.

SECTION III: HEALTH PLAN COVERAGE SELECTION

A. I elect Medical coverage -- make plan selection below

- Aetna CDHP
- Paramount Healthcare (PHC)
- I waive Medical coverage

- C. I elect Dental coverage
- I waive Dental coverage

- B. I elect Pharmacy (Rx) coverage
- I waive Pharmacy (Rx) coverage

- D. I elect Vision coverage
- I waive Vision coverage

For HR Office Use Only

DOH _____ F/T _____

Group # _____ P/T _____

Coverage Level _____ Ded Code _____

Med/Rx _____

Dental _____

Vision _____

SECTION IV-A: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION

(Please list self and all family members to show new coverage)

Name	Relationship to Employee (see below)	Birth Date (M/D/Y)	Gender		Social Security Number	Choose coverage for employee and each eligible dependent:								PCP (if PHC is selected)
			M	F		Medical		Rx		Dental		Vision		
						Yes	No	Yes	No	Yes	No	Yes	No	
Employee (in SECTION I)	1													

*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.

If you or your dependents have other coverage, 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 (under age 24 unless fully disabled) 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 between the age of 19 and 24, 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: EMPLOYEE AND ELIGIBLE DEPENDENT ENROLLMENT INFORMATION (cont'd)

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

Name	Relationship to Employee	Birth Date (M/D/Y)	Gender		Social Security Number	Choose coverage for employee and each eligible dependent								PCP (if PHC is selected)	
			M	F		Medical		Rx		Dental		Vision			
						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 COVERAGE

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, Transportation Center, Mail Stop 205 Fax: (419) 530-1492