



HEALTH INSURANCE FORM

Social Security No.	Last Name	First Name	Initial	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Mo. Day Yr.
Home Address	Number Street			Date Employed	
	City		State	Zip Code	Promotion Date
	Home Phone Number		Work Phone Number	Cell Phone Number	

Department/Division	CHRIS Employee No.
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<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Equal Partnership	If adding spouse, marriage date:	Mo. Day Yr.	Salary Division
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I ask to: <input type="checkbox"/> Become enrolled <input type="checkbox"/> Transfer to this group <input type="checkbox"/> Add spouse <input type="checkbox"/> Drop spouse <input type="checkbox"/> Add equal partner <input type="checkbox"/> Drop equal partner <input type="checkbox"/> Add dependent(s) <input type="checkbox"/> Drop dependent(s) <input type="checkbox"/> Change name <input type="checkbox"/> Change address <input type="checkbox"/> Change other ins. info.	<input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment <input type="checkbox"/> Salary Div. change Date to change name or address Mo. Day Yr. Date to add or drop dependent	Is your spouse/equal partner employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Spouse/Equal Partner Employer: PLEASE SELECT: Cincinnati 80/20 <input type="checkbox"/> Single <input type="checkbox"/> Family Dental (Fire, Management, Building Trades only) <input type="checkbox"/> Single <input type="checkbox"/> Family Vision (Fire, Management, Building Trades only) <input type="checkbox"/> Single <input type="checkbox"/> Family *FOP & AFSCME union employees need to contact their unions for information regarding dental and vision benefits.*
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In order for the City to coordinate benefits (i.e., Healthy Lifestyles Program, etc.), please indicate if spouse/equal partner is another City employee or in the City Retirement system. City Employee City Retiree

Name _____ Social Security Number _____

In the space below, list only the PERSONS you are enrolling, adding or dropping. If the person has other insurance, please indicate and provide details. Attach copies of other insurance cards. See reverse side for instructions regarding eligibility and required supporting documentation.

Name - First	M Initial	Last (if different from Employee)	Date of Birth	Relationship	Sex (M or F)	Dependents' Social Security No.	Name of other Health Ins., if applicable (specify)	Other Ins.	Medicare
Street Address	City	State	Mo. Day Yr.					Y / N	Y / N
1.									
Address							Policy No.		
2.									
Address							Policy No.		
3.									
Address							Policy No.		
4.									
Address							Policy No.		
5.									
Address							Policy No.		

I certify all information is true and correct to the best of my knowledge. I understand that by applying for the type of coverage checked, I authorize my employer to deduct from my wages, if necessary, the required premiums for the coverage hereon applied for. I further authorize any provider of medical, dental, or vision services, insurance company or any other organization to release to the City's health insurance company information regarding my coverage.

Employee Signature _____ Date _____

RISK MANAGEMENT USE ONLY: Effective Date: _____

INSTRUCTIONS TO COMPLETE THIS APPLICATION

ELIGIBILITY & SUPPORTING DOCUMENTATION

- If you are a new employee, you must complete this form and return with all supporting documentation within 31 days of the benefit eligibility date. Otherwise, you must wait until Open Enrollment to enroll in benefits.
- If you are a current employee making changes due to a qualifying life event (change in dependent disability, change in other coverage, birth, death, marriage, divorce, custody, change in equal partner status, etc.) you must complete this form and return with all supporting documentation within 31 days of the qualifying life event. If you are a current employee adding a newborn, you have up to 90 days to provide a copy of the birth certificate only. You are still required to complete this application within 31 days of the birth. Otherwise, you must wait until Open Enrollment to enroll in benefits.
- If you are a current employee who has transferred between salary divisions, this application must be completed and returned to Risk Management within 31 days.
- To be eligible for coverage as a dependent, the dependent must be listed on this health insurance application and be the employee's: legal spouse or equal partner; child (natural child, adopted child, and/or child who the group has determined is covered under a "Qualified Medical Child Support Order"); step-child or child for whom the employee or the employee's spouse/equal partner is a legal guardian.
- To add a spouse, a copy of a state issued marriage certificate and a copy of the front page of the most recent tax return (the dollar amounts should be marked out) are required. You do not need to provide a tax return if you have been married less than twelve months. To remove a spouse outside of open enrollment, a copy of the divorce decree, dissolution, or legal separation is required.
- To add an equal partner, the Affidavit of Declaration of Financial Interdependence Equal Partner Eligibility Status must be completed, notarized, and submitted with copies of supporting documentation. To remove an equal partner, the Affidavit of Termination of Declaration of Financial Interdependence must be completed and notarized. Contact Risk Management for the affidavits.
- To add a child, their social security number and copy of their birth certificate is required. If an employee has adopted a child or has legal guardianship, copies of court papers are required.
- All supporting documentation must be returned with this completed application.

STATE OF OHIO EXTENSION OF DEPENDENT COVERAGE

- Dependent children under the age of 26 are eligible for Cincinnati's 80/20 plan for medical and Rx coverage under the family rate, regardless of school status, marital status or place of residence. Dependent children age 26 to 28, who are unmarried, residents of the state of Ohio or full time students, and have no other available insurance, are eligible for coverage for an additional cost. To apply for the extension of coverage, the State of Ohio Extension of Dependent Coverage Form must be completed. Contact Risk Management for pricing and the form.

RETURN TO: PHYLISS WARD
RISK MANAGEMENT
TWO CENTENNIAL PLAZA
805 CENTRAL AVE SUITE 100
CINCINNATI, OH 45202
P 513 352 2566
F 513 352 3761

The City of Cincinnati reserves the right to request additional information if needed.