

STATE OF OHIO
BENEFIT ENROLLMENT/CHANGE FORM

Use this form to select coverage, to change coverage, or to make changes to dependent information.

Instructions:

- You may print this form and complete it by hand or enter the information online, print, sign and return to your agency benefits coordinator.
- Ensure that Section I, II, and III are completed in their entirety.
- If you are a bargaining unit employee and requesting dental/vision coverage through Union Benefits Trust (UBT) you must go to the UBT website at www.benefitstrust.org and complete their enrollment form.
- Ensure that all dependents and their information are listed.
- You are required to submit documentation that verifies dependent eligibility when you initially enroll or have a change in status/qualifying event. Documentation requirements can be found on the DAS website <http://das.ohio.gov/EligibilityRequirements>. The deadline for submitting your documentation is 31 days after your date of hire or the date of your change in status/qualifying event. Your dependents are ineligible for benefit coverage until all required documentation has been submitted.

SECTION I – EMPLOYEE INFORMATION *(please print legibly)*

State of Ohio User ID	Last Name	First Name	M.I.
Home Address (Cannot be a P.O. Box)		City	State
Phone <input type="checkbox"/> Home <input type="checkbox"/> Mobile		Work Phone	
SECTION II – ENROLLMENT INFORMATION			
Event <input type="checkbox"/> New hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change in Status/Qualifying Event (check event in the following section) <input type="checkbox"/> Exempt/Bargaining Unit change ¹ (dental/vision coverage only)			
Date of Change in Status/Qualifying Event²: _____			

¹Dental and vision options may differ for bargaining unit versus exempt employees.

²If the Date of Change in Status/Qualifying Event is more than 31 days prior to today's date, an appeal form must accompany this submission. Please see your agency human resources office to obtain the appeal form.

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Change in Status/Qualifying Events	
<input type="checkbox"/> Divorce/Marriage	<input type="checkbox"/> Qualified Medical Child Support Order (QMCSO)
<input type="checkbox"/> Gain or loss of other employer coverage	<input type="checkbox"/> Dependent no longer meets eligibility requirements
<input type="checkbox"/> Student Status Change (Dental/Vision only)	<input type="checkbox"/> Other Circumstances: _____
<input type="checkbox"/> Birth/Adoption	

Name	Dependent Type	Date of Birth	Gender	Plan (Check all boxes that apply) Check A or C for each if applicable A=Add C=Cancel
Employee Same as above <input type="checkbox"/> Add <input type="checkbox"/> Cancel	Self		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C
Spouse Last: _____ First: _____ SSN: _____	<input type="checkbox"/> Married Spouse <input type="checkbox"/> Common Law Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C

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Name	Dependent Type	Date of Birth	Gender	Marital Status	Plan (Check all boxes that apply) Circle A or C for each if applicable A=Add C=Cancel
Child Last: _____ First: _____ SSN: _____	<input type="checkbox"/> Child under age 26 <input type="checkbox"/> Stepchild under age 26 <input type="checkbox"/> Foster child under age 26 <input type="checkbox"/> Legal Guardianship/Ward is under age 26 <input type="checkbox"/> Disabled <input type="checkbox"/> Student (age 19-23) for dental/vision coverage only		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C
Child Last: _____ First: _____ SSN: _____	<input type="checkbox"/> Child under age 26 <input type="checkbox"/> Stepchild under age 26 <input type="checkbox"/> Foster child under age 26 <input type="checkbox"/> Legal Guardianship/Ward is under age 26 <input type="checkbox"/> Disabled <input type="checkbox"/> Student (age 19-23) for dental/vision coverage only		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C
Child Last: _____ First: _____ SSN: _____	<input type="checkbox"/> Child under age 26 <input type="checkbox"/> Stepchild under age 26 <input type="checkbox"/> Foster child under age 26 <input type="checkbox"/> Legal Guardianship/Ward is under age 26 <input type="checkbox"/> Disabled <input type="checkbox"/> Student (age 19-23) for dental/vision coverage only		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C
Child Last: _____ First: _____ SSN: _____	<input type="checkbox"/> Child under age 26 <input type="checkbox"/> Stepchild under age 26 <input type="checkbox"/> Foster child under age 26 <input type="checkbox"/> Legal Guardianship/Ward is under age 26 <input type="checkbox"/> Disabled <input type="checkbox"/> Student (age 19-23) for dental/vision coverage only		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Medical <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Dental <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> Vision <input type="checkbox"/> A <input type="checkbox"/> C

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Terms and Conditions:

1. I have read the provisions of dependent eligibility. Specifically, I have read and agree to the dependent eligibility rules that can be accessed at www.das.ohio.gov/benefits. Further, by submitting my benefit choices, I certify that the dependent(s) under my coverage comply with these eligibility rules. Importantly, I understand that enrolling an ineligible dependent(s) may be considered fraud, and could result in disciplinary actions up to and including removal. In addition, my employer may decide to initiate court or collections action for any fraudulently paid monies.

I understand that I may be subject to an eligibility audit during any benefit year in which I am enrolled for benefits coverage. I may also be required to supply documentation such as certified birth certificate(s), marriage certificate(s), front/last page of income tax returns or other documentation related to the eligibility of my dependents. Finally, I understand that if it is found that I have fraudulently obtained benefit coverage for a dependent, I may be held financially liable by the provider for the cost of any claims paid for that dependent. If enrolling for coverage, which I understand is voluntary, I authorize the deduction from my paycheck for the cost of coverage, which I have elected. I understand that payment on a pre-tax basis means that my gross pay will be reduced by the cost of the coverage before any applicable taxes are deducted.

I acknowledge that the information on this Benefit Enrollment/Change Form is complete and accurate. I understand that the information provided on this Form will be used to determine eligibility for coverage. Incomplete/inaccurate information could provide the basis to refuse or revoke coverage and may result in disciplinary action up to and including removal.

2. If waiving health insurance coverage at this time, I understand I will have to wait until the next open enrollment period in order to enroll in any of the Plans, unless I have a change in status/qualifying event.
3. I cannot start, stop, or change any pretax election until the next open enrollment unless I experience a change in status/qualifying event. If I experience a change in status/qualifying event, I must complete the Benefit Enrollment/Change Form within 31 days of the change in status/qualifying event and provide applicable supporting documentation.
4. Any change made in anticipation of a qualifying event will not be allowed. No dependents can be added or dropped from coverage until the qualifying event has occurred.
5. I acknowledge the requirement that my and my dependent's Social Security Numbers may be used as identifiers, as required under the Health Insurance Portability and Accountability Act (HIPAA). Social Security Numbers are required for all dependents.
6. Unless otherwise prevented by law, I authorize, for myself and my dependents, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information to the insurance provider or its authorized representatives. Furthermore, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances in relation to health benefit coverage and care.

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- You are responsible for enrolling/disenrolling a dependent that becomes eligible/ineligible under the plan provisions.
- You must notify your agency's benefits representative and submit the required documentation within 31 calendar days of the change in status/qualifying event.²
- Please review the "Required Documents Worksheet for Adding and Maintaining Dependents" and "Required Documents for Disenrolling Dependents" and confirm your dependents are eligible or not eligible for coverage by completion of this form and the submission of the required documents.
- **Please return the completed form with all required documents to your agency human resources office.**

²For exceptions to this, please review the information below.

By signing this form, I attest that I have reviewed the Dependent Eligibility Definitions and that the information I am submitting is true and accurate.

Signature: _____

Date: _____

Telephone: _____

Best time to call: _____

Mailing Address: _____

E-mail Address: _____

If you are unable to obtain certain documents (e.g. birth or marriage certificate) within the required deadline, you may initiate the enrollment/disenrollment process without submitting all the required documentation. See the requirements below -- if you do not meet these requirements your change request will be denied. **Please note: The coverage change will not be processed until all forms and proof of eligibility are received and approved.**

- You must *initiate* the enrollment/disenrollment process and submit as much documentation as possible within 31 days of the qualifying/change in status event; and
- You must provide a valid reason with your submission as to why documentation is missing, along with an estimated date when it will be available; and
- You must submit the required missing documentation within 31 days from the receipt of the document to your agency for processing.

If you believe this situation applies to you, please include the name of the delayed document, reason for the delay and an estimated date of when the document will be available below.

Missing Document: _____

Estimated date of submission: _____

Reason: _____