

**Terms and Conditions:**

1. I have read and agree to the provisions in the *Benefits Decision & Comparison Guide*, the Department of Administrative Services, Benefits Administration Services Web site ([www.ohio.gov/employeebenefits](http://www.ohio.gov/employeebenefits)) and/or the summary plan descriptions for the plan year in which I am enrolling. Specifically, I have read and agree to the eligibility rules provided at [www.ohio.gov/employeebenefits](http://www.ohio.gov/employeebenefits). My signature below certifies that all of my dependents I am enrolling for benefit coverage comply with these rules. I understand the enrolling of ineligible dependents may be considered fraud and could result in disciplinary actions up to and including but not limited to employment termination and/or reduction of retirement benefits. I also understand that I may be required to supply copies of documentation such as certified birth certificate(s), marriage certificate(s), front/last page of income tax returns and other related documentation.
2. 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.
3. I acknowledge that the information on this Health Care Enrollment Form is complete and accurate. I understand that the information provided on this Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or revoke coverage.
4. If waiving health insurance coverage at this time, I understand I will have to wait to the next open enrollment period in order to enroll in any of the Plans, unless I have a qualifying family status change.
5. I cannot start, stop, or change any pretax election until the next open enrollment unless I experience a change in family status. If I experience a change in family status, I must complete a Health Care Enrollment Form within 31 days of the event and provide applicable supporting documentation of the event.
6. 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.
7. 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).
8. 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 relating to health benefit coverage and care.