ENROLLMENT/CHANGE FORM (Please Print in Ink or Type)

Employer or Plan Name **ESC of Central Ohio** ☐ Enrollment ☐ Late Enrollment ☐ Annual Re-enrollment ☐ Change

Employee Name (Last – First – Middle)	Social Security No.	Date of Birth Mo Day Yr	Sex ☐ Male ☐ Female	☐ Hourly ☐ Salaried ☐ Other

Home Address	Street Name and Number	City	State	Zip Plus 4	Home Phone Number

If new Enrollment, indicate:
Effective Date Mo Day Yr

Date waiting period began Mo Day Yr

Date of Hire Mo Day Yr

IF CHANGE, indicate:

Type of Change	Effective Date of Change
☐ Add Spouse _____ Marriage Date	
☐ Add Child(ren)	
☐ Drop Spouse	
☐ Drop Child(ren)	
☐ Change Name	
☐ Change Address	
☐ Change Beneficiary	
☐ Reinstate Coverage	
☐ Other (Describe below)	

Indicate Coverage Now Applying For:

Medical/ Drug ☐ Individual ☐ Family ☐ None

Dental ☐ Individual ☐ Family ☐ None

If "None" is checked, a waiver form must be Completed and signed.

DEPENDENTS **List below spouse and unmarried dependent children covered under this plan**

First M. Initial Last (if different from empl.)	Social Security #	Date of Birth	Relationship	M/F	Add	Drop	Resides in Your home?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

NOTE: IF THERE IS A COURT ORDER OR DIVORCE DECREE FOR ANY OF THE ABOVE DEPENDENT(S), YOU MUST SUPPLY A COPY WITH THIS FORM

If you are requesting to continue dependent status due to incapacitation, check ☐ Yes and list the dependent name: _____
You must attach a statement which states the conditions, treatments, current and future prognosis for this dependent

OTHER COVERAGE INFORMATION

Does your spouse or any dependent have other health coverage? ☐ Yes ☐ No If yes, provide:
Name(s) of Covered Person(s) _____ Effective Date _____ Coverage Type ☐ Medical ☐ Dental ☐ Vision

Employer_____
NAME ADDRESS PHONE #

Claims Payor_____
NAME ADDRESS PHONE #

Are you or any enrolled dependents covered by Medicare as the result of disability? ☐ Yes ☐ No If yes: Medicare effective date _____ Mo Day Yr

Name of covered person(s) _____

I hereby apply for group coverage for which I am or may become eligible under the above group program except those waived above. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I understand that I must meet the eligibility requirements of the Plan and that completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

Date _____ Employee Signature X _____

Date _____ Employer Representative Signature X _____

WAIVER OF ENROLLMENT RIGHTS
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

WAIVER
The benefits have been explained to me thoroughly. Unless otherwise indicated above, I DO NOT wish to enroll and understand that I will not be entitled to any benefits provided by the plan.

Date _____ Employee Signature X _____