Frederick County Public Schools

Employee/Member Enrollment or Change Application

(Please Press Firmly)

1. TYPE OF REQUEST

☐ New Applicant ☐ Coverage Change (adding or deleting spouse or child)

☐ **COBRA Applicant:** Relationship to employee/member ☐ Self ☐ Spouse ☐ Child

☐ Spouse/Parent Employed w/FCPS, Name_____ Employee ID #_____

2. APPLICANT INFORMATION

1. APPLICANT SOCIAL SECURITY NUMBER	2. NAME (LAST)	(FIRST)	(MI)

3. STREET ADDRESS	4. CITY	STATE	ZIP

5. SEX	6. MARITAL STATUS	7. DATE OF BIRTH	8. TELEPHONE NUMBERS:	9. WORK LOCATION
☐ Male ☐ Female	☐ Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced		Home Work	

3. MEDICARE INFORMATION (to be complete if applicable)

1. Are you eligible for Medicare? ☐ Yes ☐ No If Yes, Medicare Number: Hospital Effective Date: Med. Eff. Date (Part B)

2. Spouse? ☐ Yes ☐ No If Yes, Medicare Number: Hospital Effective Date: Med. Eff. Date (Part B)

3. Child? ☐ Yes ☐ No If Yes, Medicare Number: Hospital Effective Date: Med. Eff. Date (Part B)

4. OTHER INSURANCE INFORMATION

Note: This information is required and subject to verification. Failure to complete this section may delay your ID card and claims payment.

1. Are you, your spouse, or any listed children covered by other health insurance or another UnitedHealthcare Plan? ☐ Yes ☐ No
2. If Yes,

Name of Policy Holder:_____ Policy Number_____Insurance Company_____City and State_____

Effective Date: From_____Through_____

Does this policy cover: ☐ You? ☐ Your spouse? ☐ Your children?

5. COVERAGE LEVEL (Check applicable selection)

Health/Vision/RX	☐ Individual	☐ Employee + One Dependent	☐ Family	☐ Waive
Dental	☐ Individual	☐ Employee + One Dependent	☐ Family	☐ Waive
Dental Buy-Up	☐ Yes	☐ No		

6. EMPLOYEE AND DEPENDENT INFORMATION

	Last Name	First Name	MI	Date of Birth Month	Day	Year	Relationship to Applicant	Sex	Disabled
01							Member	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								
02							Spouse	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								
03							Minor Dependent List Relationship	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								
04							Minor Dependent List Relationship	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								
05							Minor Dependent List Relationship	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								
06							Minor Dependent List Relationship	❑ Male ❑ Female	❑ Yes ❑ No
	Social Security Number								

7. TERMINATION OF DEPENDENTS

Name: _____Termination Date: _____Give correct reason code:_____

Name: _____Termination Date: _____Give correct reason code:_____

Reason codes

1. Divorce
2. Death
3. Child reached age limit
4. Entered military
5. Other insurance

8. CONDITIONS OF ENROLLMENT

I hereby apply, on behalf of myself, spouse, and/or each child listed above, for the health and/or dental coverage indicated. If this application is accepted, coverage will be provided according to terms and conditions of the health and/or dental care contract between UnitedHealthcare, the dental Plan, and my Employer. I agree to be bound by the health and/or dental care contract, of which this application will become part. I also agree to pay current and future charges for the health care coverage provided in excess of any Employer contribution.

I understand that the above elections will remain in effect until the last day of the applicable period of coverage. I understand that if there is a significant change in the cost of health and/or dental coverage under the Plan, the Employer may increase automatically, during the applicable period of coverage, the payroll deductions I am required to make per pay period to purchase the health and/or dental benefits I have elected above. I understand further that the payroll deduction elections set forth above will continue in effect notwithstanding any reductions in the health and/or dental benefits I have elected above. In addition, I understand that, except in certain cases involving a significant reduction in health and/or dental coverage, or a significant increase in the cost of health and/or dental coverage under the Plan for which the Employer permits me to change my health and/or dental coverage elections, I may change the above elections before the end of the applicable period of coverage only if I experience a "status change" as defined under applicable law, or only in the case of certain special enrollment period rights I have. I may change my elections only in a manner consistent with that "status change." I understand further that, except with respect to any dependent care flexible spending account elections I have made, if I do not complete and file a new election form during the next election period, the above elections will continue in effect until changed on a subsequent election form during a subsequent election period, or until changed incident to a "status change," "Special Enrollment Event," or a significant change in the coverage or a significant increase in the cost of coverage under the Plan. I hereby agree to any increases in my salary reduction in any subsequent periods to pay for any increases in the cost of coverage in such period(s). Finally, I understand that the elections noted above may need to be modified by the Employer to insure that the Plan complies with applicable tax rules. In addition, I agree that any provider of services who has made a diagnosis, rendered treatment, or provided services in connection with any illness for which a health and/or dental care benefit is sought under the Plan, is authorized to furnish UnitedHealthcare, CVS/Caremark, and their contracted vendors, upon request, full information and records or copies relating to the diagnosis, treatment or care rendered to me or my eligible dependents. Such information shall be held confidential.

I have carefully read this application and agreed to its terms. The recorded answers on this application are, to the best of my knowledge and beliefs, full, complete and true as of this date. THIS INFORMATION IS SUBJECT TO VERIFICATION. Failure to complete any section may delay claims/payments.

Date X_____ **Signature of Applicant X**_____

YOUR EMPLOYER/GROUP ADMINISTRATOR MUST COMPLETE THIS SECTION

1. EMPLOYER SIGNATURE/VERIFICATION	2. PHONE	3. EFFECTIVE DATE REQUESTED	4. DATE OF HIRE

5. GROUP NUMBERS/PLAN VARIATION/REPORTING CODES	MEDICAL + VISION	PRESCRIPTION	DENTAL	6. EMPLOYMENT STATUS
				☐ Active ☐ Retired ☐ Cobra

Please return completed application to FCPS Benefits Office.

Revised September 2014