

Benefits Enrollment Form



New Enrollment
 Change
 Termination
 Effective Date _____ Reason for Change _____

Employer <b style="text-align: center;">CITY OF STOW		Division/Department <input type="checkbox"/> AFSCME <input type="checkbox"/> NON-AFSCME			
Member Information – All Fields Must be Completed					
Employee First Name		Employee Last Name		Middle Initial	
Street Address		City		State	ZIP
Primary Phone		Email			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Hire/Rehire Date	Date of Birth	Social Security Number (SSN) ¹	Current Marital Status <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> married <input type="checkbox"/> divorced	If Status Changed (Date of Change)

¹ Social Security numbers are required for all participants (employee and dependents) of the plan. This number will not appear on your ID card. CMS Reporting requires the plan to report this information to Medicare administration.

Benefit Options

Medical, RX & Dental Benefits: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived Benefits
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Dependents To Be Enrolled

Last Name, First Name, Mid Initial	Relationship ³	Sex	Birth Date	Social Security Number (SSN) ¹	Other Insurance:
Spouse:		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO
² Child:		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO
² Child:		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO
² Child:		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> YES <input type="checkbox"/> NO

² Proof of eligibility may be required.

³ Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify)

Other Insurance

- No members of my family listed above are covered by any other plan of insurance.
 The following members are covered by other insurance plans as noted below.

	Employee	Spouse	Child: _____	Child: _____
Policy Holder				
Insurance Company				
Coverage Tier	<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY	<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY
Coverage Type	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION

Complete this section only if you wish to waive part of the coverage offered.

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: Medical/Rx/Dental Reason for Waiving _____

Authorization	
I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation, or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Mutual Health Services. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information. ³	
Employee Signature	Date (MM/DD/YYYY)

Employer Signature _____ Date (MM/DD/YYYY) _____

Multi-Language Interpreter Services & Nondiscrimination Notice



This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-367-3762 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-367-3762 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíłnih 1-800-367-3762 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-367-3762 (TTY: 711)まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.

Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.