



Clayton County Board of Commissioners Dental Enrollment/Change Form



FOR OFFICE USE ONLY

Option I
\$1,200 Annual Maximum Per Participant

Option II
\$1,700 Annual Maximum Per Plan Participant

Waive Coverage

Pay Period

Coverage Effective Date

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Coverage Change	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Vested <input type="checkbox"/> COBRA	<input type="checkbox"/> Surviving Spouse	Changes: Outside Annual Open Enrollment period, See back of form for IRS permitted Family Status Changes Date of Event ____/____/____ <input type="checkbox"/> Marriage or Divorce <input type="checkbox"/> Residence <input type="checkbox"/> Number of Dependents <input type="checkbox"/> Judgment / Court Order <input type="checkbox"/> Loss/Addition of Other Coverage <input type="checkbox"/> Medicare/Medicaid PeachCare Entitlement <input type="checkbox"/> Significant Coverage Change	Health Code
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced/Legal Separation <input type="checkbox"/> Widow	Check Reason(s) for Change Below <input type="checkbox"/> Add Dependent <input type="checkbox"/> Cancel Coverage Reason: _____		<input type="checkbox"/> Cancel Dependent

Employee Last Name _____ First Name _____ Middle Initial _____ Employee ID Number _____

Mailing Address _____ City _____

State _____ Zip Code _____ County _____ Email Address _____

Home Telephone # _____ Cell # _____

Eligible Dependents codes: 01 -Spouse, 09 - Adopted Child, 10 - Foster Child, 15 - Ward, 17 - Stepchild, 19 - Natural Born Child, 23 - Sponsored Dependent (child up to age 26 not meeting other eligibility requirements), and 31 - Court Appointed Guardian

Dependent Code	Last Name	First Name	MI	Status (circle one)	Date of Birth	Social Security #	Sex	Disabled	Other Dental Coverage Primary?	Full-Time Student?	Custodial Parent?
Self				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	N/A	N/A
Spouse # 01				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	N/A	N/A
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N
Dep # _____				<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel				Y N	Y N	Y N	Y N

****OTHER DENTAL COVERAGE**** Primary Policyholder Name _____ Effective Date _____ ID Number _____

Employer _____ Group Number _____

Insurance Company Name _____

Insurance Company Address _____

Dental premiums to be paid with pre-tax dollars
 Dental premiums to be paid with after-tax dollars (additional authorization form required)

By signing below, I declare that I READ AND UNDERSTAND ALL INFORMATION ON THE BACK OF THIS ENROLLMENT FORM. I understand that coverage will not be effective until this enrollment form is accepted and any required waiting period has been met. I DECLARE that all statements made on this enrollment form are complete and true. I understand that material misrepresentations, omissions, concealment of facts or incorrect statements may void my eligibility for any of these coverages. I understand that information obtained on this form will be provided to third party administrators and others who require the information for the operation and payments required under the health plan. In addition, my signature authorizes the appropriate premium deductions to be made from my paycheck with pre-tax dollars unless an after-tax form is completed or after-tax from my retirement check.

Employee Signature _____ Date _____

Group Authorization _____

****It is the primary responsibility of the employee to provide all necessary and required documentation for any family status change event.****

FAMILY STATUS CHANGES

Since this Plan operates under a Flexible Benefits Plan (Section 125 IRS Code) that allows active employees to pay premiums with pre-tax dollars, we must abide by certain rules set forth under this section of the IRS Code. Generally, you must make a selection once per year (during an annual Open Enrollment period) concerning the type of dental coverage you want and the family members you want enrolled in that coverage. However, certain status changes that occur during the year will permit you to make a change in your coverage that is commensurate with the status change, provided it is done within **ONE MONTH** of the event. Status changes allowed under this Plan are:

- * Legal Marriage,
- * Divorce, Legal Separation or Annulment,
- * Coverage lost/becomes effective due to a different effective date of a spouse's plan,
- * Significant cost or coverage changes occur in the Employee or spouse's plan,
- * Child satisfies or ceases to satisfy the requirement of an eligible dependent (such as aging out),
- * Change in Employment status that affects eligibility in the applicable benefit plan that would cause the individual to cease to be eligible under that plan, including the start of or end of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, switching from part-time to full-time, etc.,
- * Becoming subject to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody-including a Qualified Medical Child Support Order issued to our Employee, or
- * Employee, spouse or dependent become entitled or loses eligibility for coverage under Medicare or Medicaid or loses coverage under any group health coverage sponsored by a governmental or educational institute, such as SCHIP or a foreign government group health plan. NOTE: Loss of coverage under SCHIP allows 60 days to notify The Plan of the status change.
- * Spouse's enrollment, disenrollment or eligibility in other group sponsored dental coverage.
- * Death of Spouse or Child,
- * Birth or Adoption of a Child,
- * Being appointed "Legal Guardian" or "Legal Custodian" of a child,

DEPENDENT COVERAGE

Dependent is any one of the following persons:

A covered Employee's legal spouse or unmarried children (as defined below) from birth to 19 years of age. A Dependent child will be eligible for coverage after age 19, provided the child is a full-time student at an accredited school, resides in the employee's principal place of abode (except for attending school), is unmarried, under age 24 and meets all other eligibility requirements. Coverage ends on the child's 24th birthday. If parents have joint custody, the County employee must have the higher gross earnings. The child may not provide more than 1/2 of their own support.

ELIGIBILITY REQUIREMENTS

A new enrollment form and documentation is required proving a marital relationship (marriage certificate), legal guardianship/custody of or adoption of a child(ren) (signed official court papers), **within one month from the date** such dependents are acquired. Failure to submit the required enrollment form and documentation within the specified time period will result in denial of coverage until the Self-Funded Plan's next Open Enrollment period.

The Plan will **require verification each quarter or semester** from the registrar's office of an accredited school that the dependent child(ren) over age 19 is a full-time student. Verification will also be accepted from the National Student Clearinghouse (www.studentclearinghouse.org). Full-time student means that the child(ren) **must attend school at least 5 consecutive months in a calendar year** and be enrolled for a minimum of 2/3rds of the full-time hour requirement for that institution (normally 12 hours each quarter or semester) for each semester or quarter. Coverage for the student continues through the last day of the month in which the student was enrolled in school. A student is granted one free semester or quarter (where they do not attend school at all or take fewer than the required 2/3rds of full-time hours) in a rolling twelve month period, provided the child(ren) met student status for the previous two semesters or three quarters.

The term "children" shall include natural children, children for whom the County employee has been named "legal guardian" or "legal custodian", adopted children or children placed with a covered Employee while adoption procedures take place. Stepchildren may also be included, as long as all other eligibility requirements are met. All children must reside in the same principal place of abode as the County employee for more than 1/2 of the taxable year (except for temporary absences to attend school, etc.) and no child is eligible for coverage if the child provides more than 1/2 of his/her own support for the year.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order or an administrative process established under state law, shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. **No other eligibility requirements are necessary if dependent coverage is a result of a Qualified Medical Child Support Order.**

Dependent coverage becomes effective when either:

- * the Employee's coverage goes into effect, provided the Dependent meets all eligibility requirements, the Employee enrolls the Dependent for coverage on the application provided by Human Resources, Benefits Division, and required contributions are paid, or
- * for newly acquired dependents, effective the date the Dependent satisfies eligibility requirements provided the Employee completes the proper notification form and submits required documentation and it is received by Human Resources, Benefits Division **within one month of the event date** and required contributions are made.

To add a newborn child to your coverage, you must complete a new enrollment form **within one month from the child's date of birth** and provide the record of birth from the hospital OR a birth certificate (if it is available). Failure to complete the enrollment form and provide the required documentation within the specified time period may result in coverage being denied. In such a case, the child could not be added to your coverage until the next Open Enrollment Period. The child's coverage would become effective at the beginning of the Plan year following the Open Enrollment Period during in which you added the child to your coverage.

To add a new spouse to your coverage, you must complete a new enrollment form **within one month from the date of marriage** and provide a copy of the Marriage Certificate. Failure to do so within the specified time period will result in your inability to add the spouse until the next Open Enrollment Period.

Dependent coverage ceases when either:

- * the spouse becomes divorced from the employee or retiree,
- * the spouse or child dies,
- * the Employee dies while in active service (not retired) unless otherwise specified,
- * the Employee's coverage is cancelled,
- * the Employee is no longer the legal step-parent of the child(ren),
- * the Employee loses legal guardianship/custody of the child(ren),
- * the child ceases to reside in the County Employee's household for more than 1/2 of the year, (except for temporary absences to attend school),
- * required contributions are not made for dependents' coverage,
- * the dependent becomes enrolled for coverage under the Plan as an Employee,
- * the dependent goes on active duty in any military service of any country,
- * the child attains age 24 or age 19 and is not a full-time student,
- * a child provides more than 1/2 of their own support,
- * the child becomes employed full-time,

A Dependent child may continue eligibility under this plan as long as the Employee continues to be covered, and they continue to meet all of the following: Incapable of self-sustaining employment by reason of mental retardation or physical handicap, which existed before the child would have otherwise become ineligible for coverage. The Benefits Division must be notified in advance of the child reaching the maximum age for dependent status prior to the child aging out in order for the coverage to be continued due to a physical or mental disability. The Plan reserves the right to require proof that a spouse or child(ren) qualifies or continues to qualify as a Dependent.

In no event will a child(ren) be covered as a Dependent of more than one Employee.

No other person living in a covered Employee's home is eligible for coverage other than those previously outlined.

The Plan reserves the right to require proof that a spouse of child(ren) qualifies or continues to qualify as a Dependent.