Clayton County Board of Commissioners
Human Resources, Benefits Divison
Self-funded Medical Plan Enrollment/Change Form and Payroll Reduction Authorization

FOR OFFICE USE ONLY
Pay Period
Coverage Effective Date
Health Code
Is Spouse also a County Employee? ☐ Yes ☐ No
Date of Hire
Department

Check All That Apply
- ☐ **New Enrollment**
- ☐ **Open Enrollment**
- ☐ **Coverage Change**

Employment Status
- ☐ **Active** ☐ **Vested** ☐ **Surviving Spouse**
- ☐ **Retiree** ☐ **COBRA**

Marital Status
- ☐ **Single** ☐ **Divorced/Legally Separated**
- ☐ **Married** ☐ **Widowed**

Check Reason(s) for Change Below
- ☐ **Add Dependent** ☐ **Cancel Dependent**
- ☐ **Cancel Medical**

Reason: _____

Changes: Outside of the Annual Open Enrollment period, the IRS only allows change(s) for certain "Permitted Election Changes" as outlined on the back of this form.
If making a change, complete the following:
Date of Event _____/_____/_____

- ☐ **Legal Marriage / Divorce** ☐ **Residence**
- ☐ **Number of Dependents** ☐ **Judgment / Court Order**
- ☐ **Loss of or Addition of Other Coverage** ☐ **Medicare / Medicaid Entitlement**
- ☐ **Significant Coverage Change**

Employee Name (Last) (First) (MI) Employee Number

Mailing Address (City) (State) (Zip Code) (County) Home Phone

GA Clayton

Email Address

Eligible Dependents codes: Spouse; 01, Adopted Child; 09, Foster Child; 10, Ward; 15, Stepchild; 17, Natural Born Child; 19, Sponsored Dependent; 23, and Court Appointed Guardian; 31.

Relationship to Employee Codes	Last Name	First Name	MI	Medical	Date of Birth	Social Security #	Sex	Disabled?	Other Medical Coverage Primary?	Other Rx Coverage Primary?	Full-Time Student?	Custodial Parent?
Self				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	N/A	N/A
Spouse--# 01				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	N/A	N/A
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Dep--# ____				☐ Enroll ☐ Cancel			☐ F ☐ M	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

****OTHER MEDICAL COVERAGE** Primary--Please provide the following information:**
Policyholder **Employer** **Effective Date** **ID Number**

Insurance Company Name and Address **Group Number**

****OTHER Rx COVERAGE** Primary--Please provide the following information:**
Policyholder **Employer** **Effective Date** **ID Number**

Insurance Company Name and Address **Group Number**

****MEDICARE Enrollees** -- Please provide the following information:** **If retired, must enroll in Humana Medicare Advantage.**
Employee / Retiree / Dependent Name Medicare # Part A Effective Date Part B Effective Date

Employee / Retiree / Dependent Name Medicare # Part A Effective Date Part B Effective Date

Please check the options that apply to your coverage selection:

☐ I elect to participate in the CCBOC Self-funded Medical Plan Standard Option & authorize my premiums to be paid with pre-tax dollars from my paycheck or after-tax dollars from my retirement check.

☐ I elect to participate in the CCBOC Self-funded Medical Plan Lifestyles Management Plan & authorize my premiums to be paid with pre-tax dollars from my paycheck or after-tax dollars from my retirement check. I understand that there are specific provisions with this plan and may be removed from this plan and enrolled into the CCBOC Self-funded Medical Plan Standard Option.

☐ I elect to waive enrollment in ALL medical plans offered by CCBOC.

☐ I elect to pay my medical premiums with after-tax dollars. (An additional form must be completed for the Finance Department.)

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.

Sign Here After Printing

Employee Signature _____ **Date** _____

Group Authorization Signature _____

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 medical and/or 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 is lost or 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,
* Death of Spouse or Child,
* Birth or Adoption of a Child,
* Being appointed "Legal Guardian" or "Legal Custodian" of a child,
* A change in the place of residence of the employee, spouse, or dependent that affects eligibility (such as moving out of an HMO service area.).
* Child satisfies or ceases to satisfy the requirement of an eligible dependent (such as aging out, failing to meet required student status, fails to reside in the employee's household, gets married, etc.),
* 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.
* Spouse's enrollment, disenrollment or eligibility in other group sponsored medical and/or dental coverage (may effect the assessment of the medical spousal premium surcharge).

DEPENDENT COVERAGE

Dependent is any one of the following persons:

A covered Employee's legal spouse or unmarried children from birth to 19 years of age. However, 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.

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. **Full-time student** means that the child(ren) **must attend school at least 5 months in each 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).

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 who reside in the Employee's household 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 Divison **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 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 dependent goes on active duty in any military service of any country,
* the dependent becomes enrolled for coverage under the Plan as an Employee,
* the individual ceases to satisfy the requirements of a "Dependent" for any reason,
* required contributions are not made for dependents' coverage,
* a child provides more than 1/2 of their own support
* the child gets married,
* the child attains age 24 or age 19 and is not a full-time student,
* the child becomes employed full-time,
* the child ceases his/her full-time student status between the ages of 19 and 24,
* the child dies
* the child no longer resides more than 1/2 of the year in the employee's household (except for temporary absences to attend school)

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 Divison 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.
* Reside more than 1/2 of the calendar year with the County employee (except for temporary absences to attend school, etc.)
* If parents have joint custody, the County employee must have the higher gross earnings. The child may not provide more than 1/2 of his/her own support.
* Remain unmarried and meet all other "Dependent" requirements at the time they would have otherwise become ineligible.

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 or child(ren) qualifies or continues to qualify as a Dependent.