GENESEE COUNTY
INSURANCE ENROLLMENT/CHANGE/DELETION FORM

New Retiree

Employee Name _____ **Social Security #** _____-_____-_____ **Phone #** (_____) _____- _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth _____/_____/_____ **Date of Qualifying Event:** _____/_____/_____ **Effective Date:** _____
(Internal use only)

	Single	**Two-Party**	**Family**
Blue Cross Blue Shield (PPO)	☐	☐	☐
HAP (PPO)	☐	☐	☐
HAP (HMO)	☐	☐	☐
OPT OUT	☐		

(Internal use only)
007000372-21 RX _____ LIFE _____
10004948 STD ☐ LTD ☐
10004947 Express Scripts EXS000000003246

OPTICAL/DENTAL INSURANCE

National Vision Administrators	☐	☐	☐
Delta Dental of Michigan	☐	☐	☐

(Internal use only) **Effective Date** _____
52043000002 VIS _____
1888- DEN _____

CONTRACT ADDITION: ☐ ***DELETION:*** ☐ ***CHANGE:*** ☐ ***Reason:*** _____
NO CHANGES: ☐ ***(E.G. birth of child, divorce, lost coverage, changing plans, etc)***

****List ALL members (Include anyone on the contract that is being deleted and note reason for deletion under description)***

Put an X if this person's coverage is changing	**Full Legal Name**	**Relation-ship**	**M/F**	**SSN**	**DOB**	**HMO Only- Doctor's Name**	**Coverage** Health & RX	Dental	Vision	**Description or n/c for no change**
X	**Jonathan Doe III**	**DEP**	M	XXX-XX-XXXX	01/01/1999	Dr. Smith	n/a	X	X	Add Dental/Vision Only
☐		**Self**						☐	☐	
☐		**Spouse**						☐	☐	
☐		**DEP**						☐	☐	
☐		**DEP**						☐	☐	

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G E N E S E E C O U N T Y
INSURANCE ENROLLMENT/CHANGE/DELETION FORM

Put an X if this person's coverage is changing	Full Legal Name	Relation-ship	M/F	SSN	DOB	HMO Only- Doctor's Name	Coverage Health & RX	Dental	Vision	Description or n/c for no change
☐		DEP						☐	☐	
☐		DEP						☐	☐	
☐		DEP						☐	☐	
☐								☐	☐	
☐								☐	☐	

(Please attach copy of birth certificate for any child you are adding and a marriage certificate for the spouse.)

I attest that the child I am enrolling for coverage meets the following criteria:
Is under age 26 and is my child through blood, marriage or legal adoption.

I certify that I read the important information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the health care contract void and refuse all allowance of the benefits to any person under the contract.

_____ _____

Employee's Signature (Do Not Print) Date **HR Representative's Signature Date**

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