

5721

Group

CITY OF CHARLESTON

BENEFIT PLAN ENROLLMENT CARD

	XXXXXXXX	
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Location

Department

Active Retiree Widow

Effective Date of Coverage
____/____/____
Hire Date
____/____/____

Employee Information

Name _____

(First) (Middle) (Last)

Social Security Number/Put Above

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Department/Put In Box

Address _____

	Street	City	State	Zip Code
Sex	Date of Birth ____/____/____	Marital Status:	<input type="radio"/> Single	<input type="radio"/> Widowed
<input type="radio"/> Male			<input type="radio"/> Married	<input type="radio"/> Separated
<input type="radio"/> Female	Telephone# _____		<input type="radio"/> Divorced	

MEDICAL

- elect single
- elect employee + one child
- elect employee + spouse
- elect employee + children
- elect family
- do no elect coverage

VISION

- elect single
- elect employee + one child
- elect employee + spouse
- elect employee + children
- elect family
- do no elect coverage

Names of Dependents To Be Covered:

Name	Social Security Number	Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Have you or any of your dependents had previous health coverage? Yes No If "YES", complete the following boxes, including the effective and cancel dates.

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date/Cancel Date	Coverage Type(s)
				<input type="radio"/> Medical <input type="radio"/> Prescription Drug
				<input type="radio"/> Dental <input type="radio"/> Vision
				<input type="radio"/> Medical <input type="radio"/> Prescription Drug
				<input type="radio"/> Dental <input type="radio"/> Vision

REASON FOR CANCELING

*Check box below for each individual receiving treatment for end-stage renal disease.

Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.

<input type="radio"/> You	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
<input type="radio"/> Spouse	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
<input type="radio"/> Dependent	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease

Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.

1. Dependent City & State	2. Dependent City & State
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Employee Signature

Date

Healthcare Premium Discount Enrollment Verification

Overview & Instructions: The City of Charleston offers eligible full-time employees a Health Risk Management (HRM) or Non-Tobacco User (NTU) healthcare premium discount. In order to receive the HRM or NTU discount eligible employees must enroll and comply with the HRM or NTU program discount requirements. A complete description of each discount can be found in Section I. Please review each description and select the box adjacent to the premium you would like to enroll for the 2016 benefit year. If you enroll in the City's healthcare plan, **you must select one (1) box in Section I.** Complete Section II in its entirety, and sign and date the enrollment form in Section III. **Please return your completed form to the Office of Human Resources on or before December 1, 2015.**

Section I. Healthcare Premium Selection (Please Select only 1 Box)

Standard Rate: Select this option if you do not want to enroll in the Health Risk Management (HRM) Program or receive the Non-Tobacco User discount.

Health Risk Management (HRM) Discount: The City has partnered with CareHere, the operator the City of Charleston Employee Wellness Center and the Pharm UC Patient Care Clinic at the University of Charleston to offer an HRM Program to eligible employees. To participate in the HRM Program and be eligible to receive a discounted healthcare premium, you must certify and agree that you and your covered spouse, if applicable, will adhere to the program requirements including, but not limited to keeping appointments with Wellness Center and/or Pharm UC staff, complying with any program(s) prescribed by Wellness Center and/or Pharm UC medical professionals and agree to participate in random nicotine screenings.

Non-Tobacco User (NTU) Discount: Select this option if you do not want to participate in the HRM Program, but would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products, and that you agree to participate in random nicotine screenings.

Section II. Employee Information (Please Print)

Name: _____ Department: _____

Address: _____

City: _____ State: _____ Zip: _____ **Section III.**

Certification

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge. I further understand that by enrolling in the HRM Program or electing to receive the NTU discount, by checking the designated box in Section I herein, that I agree to the applicable requirements in order to receive the associated discount. I also acknowledge and understand the City or its authorized agent may access my medical records for purposes of verifying my status as a tobacco user.

Employee Signature

Date

