EMPLOYEE MEDICAL HEALTH PLAN SUFFOLK COUNTY

HEALTH BENEFITS TRANSACTION FORM

SUFFOLK COUNTY EMHP
Employee Medical Health Plan of Suffolk County

INSTRUCTIONS:
NEW ENROLLMENT - FILL OUT SECTION 1, 2, AND 4
CHANGE IN STATUS - FILL OUT SECTION 1, 3, AND 4

SECTION 1

① LAST NAME | FIRST NAME | MI

④ ENROLLEE'S SOCIAL SECURITY NUMBER

⑤ ENROLLEE'S DATE OF BIRTH MONTH DAY YEAR

② STREET ADDRESS

⑥ MARITAL STATUS
☐ (1) SINGLE ☐ (2) MARRIED ☐ (3) WIDOWED ☐ (4) DIVORCED ☐ (5) DOMESTIC PARTNER

P. O. BOX RURAL ROUTE

⑦ ENROLLEE'S SEX
☐ (1) MALE ☐ (2) FEMALE

⑧ SPOUSE/PARTNER'S SOCIAL SECURITY #

③ CITY | STATE | ZIP CODE

SPOUSE/PARTNER'S EMPLOYER

HOME PHONE NO. | BUSINESS PHONE NO. | SPOUSE/PARTNER'S PHONE NO.

THIS SECTION TO BE COMPLETED BY NEW EMPLOYEE

SECTION 2

⑨ ☐ EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY ☐ HMO SPECIFY HMO OTHER

⑩ COVERAGE ☐ (1) INDIVIDUAL ☐ (2) FAMILY (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW)

⑪ PREVIOUS COVERAGE COMPLETE ONLY IF COVERAGE UNDER YOUR PREVIOUS HEALTH INSURANCE HAS TERMINATED OR WILL TERMINATE WITHIN TWO MONTHS
PREVIOUS COVERAGE WAS AS A(N) ☐ ENROLLEE ☐ DEPENDENT

NAME OF ENROLLED EMPLOYEE | REASON FOR TERMINATION OF COVERAGE

NAME OF EMPLOYING AGENCY | PREFIX | IDENTIFICATION NUMBER OF EMPLOYEE | COVERAGE TERM DATE MONTH DAY YEAR

THIS SECTION TO BE COMPLETED FOR A CHANGE IN STATUS

SECTION 3

⑫ OPTION CHANGE TO ☐ EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY ☐ HMO SPECIFY HMO SPECIFY HMO

⑬ ☐ CHANGE TO INDIVIDUAL COVERAGE REASON DATE OF EVENT MONTH DAY YEAR

⑭ (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW)
☐ CHANGE TO FAMILY COVERAGE REASON DATE OF EVENT MONTH DAY YEAR

⑮ LAST NAME FIRST NAME MI.
☐ NAME CHANGE PREVIOUS NAME WAS

⑯ ☐ CANCELLATION I VOLUNTARILY CANCEL MY HEALTH INSURANCE FOR MYSELF AND MY DEPENDENTS SIGNATURE X DATE SIGNED MONTH DAY YEAR

IF YOU APPLIED FOR FAMILY COVERAGE, LIST ALL ELIGIBLE DEPENDENTS HERE (including spouse or domestic partner)

SECTION 4

⑰ FULL NAME LAST NAME FIRST NAME MI.	RELATIONSHIP	DATE OF BIRTH	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE	DATE ENROLLED	ANTICIPATED DATE OF GRAD

⑱ ☐ REQUEST TO PARTICIPATE

I certify that the information supplied by me is true and correct, I understand that it is solely my responsibility to timely notify, in advance where possible, Suffolk County of any changes that may affect coverage of myself or of any of my enrolled dependents. I further understand that my failure to so timely notify Suffolk County of any change in status that would affect coverage shall render me solely responsible for reimbursing the County for any claims paid on behalf of an ineligible enrollee or dependent. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.

Signed _____ Signature of employee Date _____

☐ WAIVER OF BENEFITS

I do not participate in the Employee Medical Health Plan of Suffolk County offered through my employer, and I understand that I may subject myself and/or my eligible dependents to certain applicable waiting periods if I decide to enroll at a later date.

Signed _____ Signature of employee

Date _____

FOR AGENCY USE ONLY

SECT 5

	⑲ TXN CODE	⑳ TXN EFFECTIVE DATE MONTH DAY YEAR	㉑ FUND/APPR	㉒ DEPT NAME	㉓ DATE EMPLOYED MONTH DAY YEAR	㉔ DATE OF FIRST ELIGIBILITY MONTH DAY YEAR

㉕ DATE EMPLOYMENT TERM MONTH DAY YEAR	㉖ DATE ELIGIBILITY LOST MONTH DAY YEAR	㉗ NEG UNIT	㉘ NAME OF RETIREMENT SYSTEM	㉙ DATE RETIRED MONTH DAY YEAR	㉚ DATE OF DEATH MONTH DAY YEAR

EMPLOYEE MUST COMPLETE REVERSE SIDE

HEALTH INSURANCE COORDINATION OF BENEFITS FORM

The EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY has a Coordination of Benefits Provision that applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment. New employees should return the completed form to their Payroll Office. All others, please return completed form to the Employee Benefits Unit, P.O. Box 6100, Bldg. # 158, North County Complex, Hauppauge, NY 11788-0099.

SECTION I.

OTHER COVERAGE A:

NAME OF DEPENDENT WITH OTHER COVERAGE (including spouse or domestic partner)	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX

NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS:
EFFECTIVE DATE	TERMINATION DATE

OTHER COVERAGE B:

NAME OF DEPENDENT WITH OTHER COVERAGE (including spouse or domestic partner)	POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH	SEX

NAME OF OTHER EMPLOYER	ADDRESS OF OTHER EMPLOYER
NAME OF OTHER INSURANCE CARRIER	ADDRESS OF OTHER INSURANCE CARRIER
TYPE OF COVERAGE ☐ Individual ☐ Family	COMMENTS:
EFFECTIVE DATE	TERMINATION DATE

IF ADDITIONAL DEPENDENTS HAVE OTHER COVERAGE, CHECK HERE ☐

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION: This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide this information may result in a delay in payment of benefits.

FOR FURTHER INFORMATION ON THE COORDINATION OF BENEFITS FORM CONTACT YOUR PERSONNEL OFFICE
I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Signature _____ Date _____