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

EMPLOYEE MEDICAL HEALTH PLAN SUFFOLK COUNTY



HEALTH BENEFITS TRANSACTION FORM

_	-			V								
① LAST NAME FIRST NAME MI ② ENROLLEE'S SOCIAL SECURITY NUMBER ③ ENROLLEE'S DATE OAY							S DATE OF BIRTH DAY YEAR					
S												
E	② STREET ADDRESS			6 MARITAL STATUS	8			_				
C		☐ (1) SINGLE ☐ (2) MARRIED ☐ (3) WIDOWED ☐ (4) DIVORCED ☐ (5) DOMESTIC PARTNEI										
T	P. O. BOX RURAL ROUTE (1) SINGLE (2) MARHIEU (3) WIDOWED (4) DIVORCED (5) DOMESTIC PART (8) SPOUSE/PARTNER'S SOCIAL SECURIT											
1	, , , , , , , , , , , , , , , , , , ,			ا ّ	 1	000	l	I				
lo)			(1) MALE	(2) FEMALE							
N	③ CITY STAT	E ZIP CODE		SPOUSE/PAR	TNER'S EMPLOYER							
		111		1 1 1								
1	HOME PHONE NO.	BUSINESS PHO	ONE NO.		SPOUSE/PARTNER	S PHONE NO.						
•			1		1							
	<u> </u>		_ _ _ _									
THIS SECTION TO BE COMPLETED BY NEW EMPLOYEE												
S				PECIFY HMO		OTHER						
E		<u> </u>] нмо									
			1 (0) 544(1)/ (LIOT EL IONNI E DE	OCHOCHTO IN OCOT	0114 851 01						
C		L	(2) FAMILY (LIST ELIGIBLE DEF	PENDENTS IN SECTI	ON 4 BELO	vv)					
T	(6)) COMPLETE C	NLY IF COVERAGE U	INDER YOUR PREVIO	OUS HEALTH INSURA	NCE HAS TERMINATED	OR WILL TER	MINATE WITHIN	TWO MONTHS				
	PREVIOUS COVERAGE	PREVIOUS CO	OVERAGE WAS AS	S A(N)	ENROLLEE		DEPENDENT					
0	I NAME OF ENROLLED EMPLOYEE		312,11102 11110710		TERMINATION OF COVERAG		DEI ENDERT					
N				ĺ	•							
	NAME OF EMPLOYING AGENCY			PREFIX	IDENTIFICATION NUMBER	OF EMPLOYEE	COVER	AGE TERM DATE				
2						()	MONTH	DAY YEAR				
	<u> </u>					l ll.						
_	IHIS	SECTION TO E	BE COMPLETE	D FOR A CHANG	E IN STATUS			<u> </u>				
s	OPTION MEDICAL F	EALTH PLAN	П нмо ^s	PECIFY HMO		SPECIFY H	мо -					
E												
c							MONTH DATE	OF EVENT DAY YEAR				
T		REASON										
Hi	9	(LI	ST ELIGIBLE OEPENDEN	ITS IN SECTION 4 BELOW)		MONTH DATE	OF EVENT DAY YEAR				
o	CHANGE TO FAMILY COVERAGE	REASON					1 1 1	111,				
N	115)		LAST NAME		FIRST	NAME		MI.				
114	NAME CHANGE PREVIOUS NAME WAS											
	NAME CHANGE PREVIOU	S NAME WAS										
2	6	DEL MY HEALTH INSURAN	SIGNATURE		·		DAT MONTH	E SIGNED YEAR				
3	6	DEL MY HEALTH INSURAN	SIGNATURE X				MONTH DAT	E SIGNED YEAR				
3	© : VOLUNTARILY CAN'S FOR MYSELF AND M	CEL MY HEALTH INSURAN Y DEPENDENTS	X X	EPENDENTS HE	FRF (includies s	ouse or d						
3	CANCELLATION CANCELLATION CONTROL OF CONTROL	CEL MY HEALTH INSURAN Y DEPENDENTS	X X	EPENDENTS HE	ERE (including sp	oouse or d						
3	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S		oouse or d	lomestic pa	rtner)				
s	CANCELLATION OF MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME OF THE PROPERTY	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
S	CANCELLATION TOOLUNTARILY CAN FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME N	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
s	CANCELLATION TOOLUNTARILY CAN FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME N	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
SECT	CANCELLATION TOOLUNTARILY CAN FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME N	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
SECTI	CANCELLATION TOOLUNTARILY CAN'T FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV TO FULL NAME LAST NAME FIRST NAME N	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
SECTIO	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV THE YOU APPLIED FOR FAMILY COV	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	oouse or d	lomestic pa	rtner)				
SECTIO	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV THE YOU APPLIED FOR FAMILY COV	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	pouse or d	lomestic pa	rtner)				
SECTION	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME O O O O O O O O O O O O O	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	pouse or d	lomestic pa	rtner)				
SECTIO	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME O O O O O O O O O O O O O	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	pouse or d	lomestic pa	rtner)				
SECTION	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME O O O O O O O O O O O O O	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR	pouse or d	lomestic pa	rtner)				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME .	ERAGE, LIST A	X LL ELIGIBLE D	DEBENDENT'S	SCHOOL OR COLLEGE		DATE ENROLLED	rtner)				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME REQUEST TO PARTICIPATE	ERAGE, LIST A BELATIONSHIP	X LL ELIGIBLE D DATE OF BIRTH	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE	F BENEFITS	DATE ENROLLED	ANTICIPATED DATE OF GRAD				
SECTION 4	CANCELLATION TO CONTROL TO PARTICIPATE I VOLUNTARILY CAN FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true	ERAGE, LIST A RELATIONSHIP and correct, I under	X LL ELIGIBLE D DATE OF BIRTH	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE WAIVER OF Light of the participal country participa	F BENEFITS	DATE ENROLLED	ANTICIPATED DATE OF GRAD				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk	RELATIONSHIP and correct, I under County of any chan	X LL ELIGIBLE D DATE OF BIRTH rstand that it is sole ges that may affect	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE WAIVER OF I do not participa Suffolk County of	F BENEFITS te in the En	DATE ENROLLED	ANTICIPATED DATE OF GRAD				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Sulfolk or of any of my enrolled dependents. I further under the control of the control o	RELATIONSHIP and correct, I understand that my failu	X LL ELIGIBLE D DATE OF BIRTH rstand that it is sole ges that may affect the to so timely notine.	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE WAIVER OF I do not participa Suffolk County of that I may subject	F BENEFITS te in the Emerget through	DATE ENROLLED	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	GANCELLATION IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County for any claims paid on behalf of an ineligible.	RELATIONSHIP and correct, I under county of any chan estand that my failure the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of any chan estand that my failure consider on the county of the count	TATE OF BIRTH DATE OF BIRTH restand that it is sole ges that may affect ges that may affect is solely responsible itent. Any person will be a solely responsible itent. Any person will be a solely responsible itent.	DEPENDENT'S SOC. SEC. NO.	SCHOOL OR COLLEGE WAIVER OF I do not participa Suffolk County of	F BENEFITS te in the Emerget through	DATE ENROLLED	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Sulfolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent information supplied by me is true.	and correct, I unde County of any chan great my failus shall render me so emrollee or dependermation shall be gui	rstand that it is sole ges that may affect irre to so timely not solely responsible fent. Any person wilty of a crime, conv.	DEPENDENT'S SOC. SEC. NO.	WAIVER OF I do not participa Suffolk County of that I may subjectain applicable date.	F BENEFITS te in the Emerget through	DATE ENROLLED	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or impri	and correct, I unde County of any chan great my failus shall render me so emrollee or dependermation shall be gui	DATE OF BIRTH DATE OF BIRTH restand that it is sole ges that may affect ure to so timely not solely responsible tent. Any person will yof a crime, converse an order for reimb	DEPENDENT'S SOC. SEC. NO.	WAIVER OF Land Suffolk County of that I may subject certain applicable date. Signed	F BENEFITS te in the Emerget through	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or imprisigned	and correct, I unde County of any chan great my failus shall render me so emrollee or dependermation shall be gui	rstand that it is sole ges that may affect irre to so timely not solely responsible fent. Any person wilty of a crime, conv.	DEPENDENT'S SOC. SEC. NO.	WAIVER OF I do not participa Suffolk County of that I may subjectain applicable date.	BENEFITS te in the En fered through t myself an waiting peri	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or impri	and correct, I unde County of any chan erstand that my failus shall render me se enrollee or dependent, as well as somment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible tent. Any person will an order for relimb Date	DEPENDENT'S SOC. SEC. NO.	WAIVER OF Land Suffolk County of that I may subject certain applicable date. Signed	BENEFITS te in the En fered through t myself an waiting peri	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide	ANTICIPATED DATE OF GRAD at Health Plan o and I understance dependents to				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Sulfolk or of any of my enrolled dependents. I further undany change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or imprisigned Signature of employee	and correct, I unde County of any chan erstand that my failu shall render me se enrollee or dependent, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible itent. Any person willity of a crime, convision an order for reimb Date FOR AGENCY L	DEPENDENT'S SOC. SEC. NO.	WAIVER OF I do not participa Suffolk County of that I may subjected atte. Signed	F BENEFITS te in the En fered through t myself an waiting perio	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide	al Health Plan o and I understand le dependents to enroll at a later				
SECTION 4	FULL NAME LAST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Sulfolk or of any of my enrolled dependents. I further undany change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or imprisigned Signature of employee	and correct, I unde County of any chan erstand that my failus shall render me se enrollee or dependent, as well as somment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible tent. Any person will an order for relimb Date	DEPENDENT'S SOC. SEC. NO.	WAIVER OF COLLEGE WAIVER OF I do not participa Suffolk County of that I may subjected atte. Signed Date Date	F BENEFITS te in the En fered through t myself an waiting perio	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide	al Health Plan o and I understand le dependents to enroll at a later				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County change in status that would affect coverage County of any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or impringing Signed Signature of employee	and correct, I unde County of any chan erstand that my failu shall render me se emrollee or dependermation shall be gui sonment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible itent. Any person willity of a crime, convision an order for reimb Date FOR AGENCY L	DEPENDENT'S SOC. SEC. NO.	WAIVER OF COLLEGE WAIVER OF I do not participa Suffolk County of that I may subjected atte. Signed Date Date	E BENEFITS te in the Endered throught myself and waiting periodical substitution of the substitution of th	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide Comployee	ANTICIPATED DATE OF GRAD at Health Plan o and I understandle dependents to enroll at a later				
SECTION 4 ®	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County change in status that would affect coverage County of any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or impringing Signed Signature of employee	and correct, I unde County of any chan erstand that my failu shall render me se emrollee or dependermation shall be gui sonment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible itent. Any person willity of a crime, convision an order for reimb Date FOR AGENCY L	DEPENDENT'S SOC. SEC. NO.	WAIVER OF COLLEGE WAIVER OF I do not participa Suffolk County of that I may subjected atte. Signed Date Date	E BENEFITS te in the Endered throught myself and waiting periodical substitution of the substitution of th	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide Comployee	ANTICIPATED DATE OF GRAD at Health Plan o and I understandle dependents to enroll at a later				
SECTION 4	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further under any change in status that would affect coverage County change in status that would affect coverage County of any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or impringing Signed Signature of employee	and correct, I unde County of any chan erstand that my failu shall render me se emrollee or dependermation shall be gui sonment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible tent. Any person will illy of a crime, convict an order for relimb Date FOR AGENCY L	DEPENDENT'S SOC. SEC. NO.	WAIVER OF COLLEGE WAIVER OF I do not participa Suffolk County of that I may subjected atte. Signed Date Date	E BENEFITS te in the Endered throught myself and waiting periodical substitution of the substitution of th	DATE ENROLLED Inployee Medic in my employer, d/or my eligibods if I decide Comployee	al Health Plan o and I understandle dependents to enroll at a later				
SECTION 4 ®	CANCELLATION FOR MYSELF AND M IF YOU APPLIED FOR FAMILY COV FULL NAME LAST NAME FIRST NAME REQUEST TO PARTICIPATE I certify that the information supplied by me is true to timely notify, in advance where possible, Suffolk or of any of my enrolled dependents. I further undany change in status that would affect coverage County for any claims paid on behalf of an ineligible misstatement of fact or conceals any pertinent infolead to substantial monetary penalties and/or imprisonant in the substantial monetary penalties and or imprisonant in the substantial mo	and correct, I unde County of any chan erstand that my failue shall render me se enrollee or dependermation shall be gui sonment, as well as	rstand that it is sole ges that may affect the to so timely not solely responsible tent. Any person will illy of a crime, convict an order for relimb Date FOR AGENCY L	DEPENDENT'S SOC. SEC. NO.	WAIVER OF COLLEGE WAIVER OF LOGIC COLLEGE I do not participa Suffolk County of that I may subject certain applicable date. Signed Date Onte Date EMPLOYS MONTH COLUMN COLUM	E BENEFITS te in the Endered throught myself and waiting periodical substitution of the substitution of th	DATE ENROLLED DATE ENROLLED DATE ENROLLED DATE OF FIRM MONTH	al Health Plan o and I understandle dependents to enroll at a later				

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:					
FFECTIVE DATE	TERMINATION DATE					
with Section 96(1) of the Person Failure to provide this information FOR FURTHER INFORMATION ON THE COORDIN	FION LAW NOTIFICATION: This information will nal Privacy Protection Law, particularly subdivention in a delay in payment of benefits.	visions (b), (e), and (f)				
Signature	Date					