

# EMPLOYEE MEDICAL HEALTH PLAN SUFFOLK COUNTY HEALTH BENEFITS TRANSACTION FORM



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

|                  |                           |  |  |                                     |  |  |   |  |  |                                      |  |  |
|------------------|---------------------------|--|--|-------------------------------------|--|--|---|--|--|--------------------------------------|--|--|
| <b>SECTION 1</b> | ① LAST NAME FIRST NAME MI |  |  | ④ ENROLLEE'S SOCIAL SECURITY NUMBER |  |  | ⑤ ENROLLEE'S DATE OF BIRTH<br>MONTH DAY YEAR  |  |  |                                      |  |  |
|                  | ② STREET ADDRESS          |  |  |                                     |  |  | ⑥ MARITAL STATUS<br><input type="checkbox"/> (1) SINGLE <input type="checkbox"/> (2) MARRIED <input type="checkbox"/> (3) WIDOWED <input type="checkbox"/> (4) DIVORCED <input type="checkbox"/> (5) DOMESTIC PARTNER |  |  |                                      |  |  |
|                  | P. O. BOX RURAL ROUTE     |  |  |                                     |  |  | ⑦ ENROLLEE'S SEX<br><input type="checkbox"/> (1) MALE <input type="checkbox"/> (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

|                           |   |  |  |  |  |                                    |                                   |  |                                      |
|---------------------------|---|--|--|--|--|------------------------------------|-----------------------------------|--|--------------------------------------|
| <b>SECTION 2</b>          | ⑨ <input type="checkbox"/> EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY   |  |  | ⑩ <input type="checkbox"/> HMO SPECIFY HMO |  |                                    | OTHER                             |  |                                      |
|                           | ⑪ COVERAGE <input type="checkbox"/> (1) INDIVIDUAL <input type="checkbox"/> (2) FAMILY (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW)  |  |  |  |  |                                    |                                   |  |                                      |
|                           | ⑫ 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) <input type="checkbox"/> ENROLLEE <input type="checkbox"/> DEPENDENT                                    |  |  |  |  |                                    |                                   |  |                                      |
| NAME OF ENROLLED EMPLOYEE |   |  |  |  |  | REASON FOR TERMINATION OF COVERAGE |                                   |  |                                      |
| NAME OF EMPLOYING AGENCY  |   |  |  |  |  | PREFIX                             | IDENTIFICATION NUMBER OF EMPLOYEE |  | COVERAGE TERM DATE<br>MONTH DAY YEAR |

### THIS SECTION TO BE COMPLETED FOR A CHANGE IN STATUS

|                  |   |  |  |  |  |  |                                 |  |  |
|------------------|---|--|--|--|--|--|---------------------------------|--|--|
| <b>SECTION 3</b> | ⑬ OPTION CHANGE TO <input type="checkbox"/> EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY                    |  |  | ⑭ <input type="checkbox"/> HMO SPECIFY HMO |  |  | SPECIFY HMO                     |  |  |
|                  | ⑮ <input type="checkbox"/> CHANGE TO INDIVIDUAL COVERAGE REASON   |  |  |  |  |  | DATE OF EVENT<br>MONTH DAY YEAR |  |  |
|                  | ⑯ <input type="checkbox"/> CHANGE TO FAMILY COVERAGE REASON (LIST ELIGIBLE DEPENDENTS IN SECTION 4 BELOW)     |  |  |  |  |  | DATE OF EVENT<br>MONTH DAY YEAR |  |  |
|                  | ⑰ <input type="checkbox"/> NAME CHANGE PREVIOUS NAME WAS  |  |  | LAST NAME FIRST NAME MI                    |  |  |                                 |  |  |
|                  | ⑱ <input type="checkbox"/> CANCELLATION I VOLUNTARILY CANCEL MY HEALTH INSURANCE FOR MYSELF AND MY DEPENDENTS |  |  | SIGNATURE X                                |  |  | DATE SIGNED<br>MONTH DAY YEAR   |  |  |

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

|                  |  |  |  |              |               |                           |                   |               |                          |
|------------------|--|--|--|--------------|---------------|---------------------------|-------------------|---------------|--------------------------|
| <b>SECTION 4</b> | ⑲ FULL NAME<br>LAST NAME FIRST NAME MI |  |  | RELATIONSHIP | DATE OF BIRTH | DEPENDENT'S SOC. SEC. NO. | SCHOOL OR COLLEGE | DATE ENROLLED | ANTICIPATED DATE OF GRAD |
|                  |  |  |  |              |               |                           |                   |               |                          |
|                  |  |  |  |              |               |                           |                   |               |                          |
|                  |  |  |  |              |               |                           |                   |               |                          |
|                  |  |  |  |              |               |                           |                   |               |                          |

⑲  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 \_\_\_\_\_ Date \_\_\_\_\_  
Signature of employee

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 \_\_\_\_\_ Date \_\_\_\_\_  
Signature of employee

### FOR AGENCY USE ONLY

|                  |  |  |  |   |  |             |            |             |                             |  |                                   |                                  |  |   |                                   |  |
|------------------|--|--|--|---|--|-------------|------------|-------------|-----------------------------|--|-----------------------------------|----------------------------------|--|---|-----------------------------------|--|
| <b>SECTION 5</b> | ⑲ TXN CODE                               |  | ⑳ TXN EFFECTIVE DATE<br>MONTH DAY YEAR |   |  | ㉑ FUND/APPR |            | ㉒ DEPT NAME |                             |  | ㉓ DATE EMPLOYED<br>MONTH DAY YEAR |                                  |  | ㉔ DATE OF FIRST ELIGIBILITY<br>MONTH DAY YEAR |                                   |  |
|                  | ㉕ DATE EMPLOYMENT TERM<br>MONTH DAY YEAR |  |  | ㉖ DATE ELIGIBILITY LOST<br>MONTH DAY YEAR |  |             | ㉗ NEG UNIT |             | ㉘ NAME OF RETIREMENT SYSTEM |  |                                   | ㉙ DATE RETIRED<br>MONTH DAY YEAR |  |   | ㉚ DATE OF DEATH<br>MONTH DAY YEAR |  |

## 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<br><input type="checkbox"/> Individual <input type="checkbox"/> 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<br><input type="checkbox"/> Individual <input type="checkbox"/> 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 \_\_\_\_\_