TOWN OF GILBERT MEDICAL PLAN Enrollment/Change Form

Group # C124

Administered by Mayo Clinic Health Solutions
7/16

Event: ☐ New Hire ☐ Open Enrollment ☐ * Marriage/Divorce/Seperation ☐ * Birth of a Child ☐ * Loss/enrollment - other plan ☐ * Other - _____

*** PROOF OF QUALIFYING EVENT REQUIRED**

Change: ☐ Coverage Termination ☐ Add/Delete Dependents ☐ Change Plan

Effective Date:

Plan Option:
☐ Legacy Plan - AZ Network
☐ Preferred Plan - AZ Network
☐ Legacy Plan - National Network
☐ Preferred Plan - National Network

Step One - EMPLOYEE INFORMATION

Employee	Last Name	First Name	Middle Initial	DOB (MM/DD/YY)	Social Security #	Employee #	Gender (Check one) ☐ M ☐ F
	Street Address (include apartment # if applicable)			City	State	Zip	Primary Phone

Step Two – DEPENDENT ENROLLMENT – DOCUMENTS REQUIRED FOR VERIFICATION OF ELIGIBILITY – LISTED ON REVERSE OF PRINT COPY

Add	Change	Delete	RELATIONSHIP	LAST NAME	FIRST NAME	MI	DOB (MM/DD/YY)	GENDER (Check)	SOCIAL SECURITY #	MARRIAGE DATE	Is Child eligible for medical plan through an employer, including spouse's?
☐	☐	☐	*Spouse*					☐ M ☐ F			
☐	☐	☐	*Child*					☐ M ☐ F			☐ Y ☐ N
☐	☐	☐	*Child*					☐ M ☐ F			☐ Y ☐ N
☐	☐	☐						☐ M ☐ F			☐ Y ☐ N
☐	☐	☐						☐ M ☐ F			☐ Y ☐ N
☐	☐	☐						☐ M ☐ F			☐ Y ☐ N
☐	☐	☐						☐ M ☐ F			☐ Y ☐ N

Step Three - OTHER HEALTH COVERAGE INFORMATION

On the day this coverage begins, will you or any family member, be covered by any other medical coverage, dental coverage or Medicare?

☐ ***Yes -- Please complete Other Health Coverage Information Form (Part B). Attach to Member Enrollment/Change Form.*** ☐ ***No -- Go to next section.***

Step Four - SIGNATURES AND AUTHORIZATION

I hereby elect insurance under the provisions of the Group Policy(ies) for which I am eligible. I authorize deductions from my wages to cover the cost of this insurance.

I authorize any physician, medical practitioner, hospital, clinic, medically related facility, insurance or reinsuring company, third party administrator, or other person having medical information about myself or my minor children to disclose such information to Mayo Clinic Health Solutions, other insurers/plans (including Centers for Medicare & Medicaid Services) and other healthcare providers as necessary for the provision or evaluation of services, the determination of claims or requests for services or benefits under my enrollment, or the administration of the plan. Such medical information includes, but is not limited to, information related to psychological, psychiatric, sickle cell anemia, alcohol and drug abuse, communicable diseases, diagnosis and treatment. I authorize Mayo Clinic Health Solutions to re-release such medical information as necessary for the purpose of treatment, payment and/or healthcare operations. I agree that a photographic copy of this authorization shall be valid as the original. I can request and receive a copy of this authorization from the plan at any time I am enrolled with this plan.

I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any plans issued based on this application. Furthermore, if any claims are paid because of any false statements or omissions on this application, then I may be required to reimburse the Plan for such claims.

Employee Signature: _____ Date: _____

DEPENDENT ELIGIBILITY VERIFICATION

Dependent eligibility for the **Town of Gilbert Medical Plan** is defined as:

- Employee/Retiree's legal spouse
- Child less than 26 years of age
- Child above age 26 who is mentally or physically disabled as verified by the Plan Administrator and who is incapable of self-sustaining employment and is dependent on the employee or spouse for support and maintenance

Dependent eligibility for the **Town of Gilbert's group Dental Plan** is defined as:

- Employee/Retiree's legal spouse
- Unmarried child less than 25 years of age
- Child above age 25 who is mentally or physically disabled as verified by the Plan Administrator and who is incapable of self-sustaining employment and is dependent on the employee or spouse for support and maintenance

Child is defined as the employee's natural child, stepchild, legally adopted child, a child for whom the employee and/or spouse have been appointed legal guardian, or a child for whom the employee or spouse is required to provide health insurance by a Qualified Medical Child Support Order.

Documentation must be submitted to Town of Gilbert Human Resources with the enrollment form. If appropriate documentation is not received, a presumption of ineligibility will be made and enrollment will not be processed.

Document Requirements:

FOR SPOUSE:
A copy of your marriage certificate **And One Of the Following**
- A copy of the front page your most recent federal tax return confirming this dependent is your spouse
- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account. The document must list your spouse's name, the date and your mailing address.

FOR CHILDREN:
A copy of the child's birth certificate (or hospital birth record) or adoption certificate naming you or your spouse as the child's parent **OR**
A copy of the court order naming you or your spouse as the child's legal guardian
Note: As the carrier has previously verified disabled dependents, no documents are required at this time.
Note for a step-child: If you are covering a stepchild and your spouse is not a covered dependent, you must also provide documentation of your current relationship to your spouse as requested above.