

OAKLAND COUNTY RETIREES MEMBERSHIP & RECORD CHANGE FORM

PERSONAL INFORMATION			COBRA ___ HPS ___ CPS ___	
Retiree Last Name	First Name	M.I.		
Home Address <input type="checkbox"/> New	City	State	Zip Code	
Telephone	Ret/Emp ID.			

HEALTH PLAN OPTIONS					
<input type="checkbox"/> BCBS PPO 1/Optum Rx	<input type="checkbox"/> BCN/BCN Rx	<input type="checkbox"/> Waive Medical/Rx			
<input type="checkbox"/> BCBS PPO 2/Optum Rx	<input type="checkbox"/> Medicare Supplemental Plan/Optum Rx	<input type="checkbox"/> Waive Dental Standard			
<input type="checkbox"/> BCBS Traditional/Optum RX	<input type="checkbox"/> Heritage Vision Standard	<input type="checkbox"/> Waive Vision Standard			
	<input type="checkbox"/> Delta Dental Standard	<input type="checkbox"/> Waive Supplemental/Rx/Reimb			

ADD Members to Plan					
EVENT	Name (First & Last)	Event Date	Date of Birth	Social Security	Sex
<input type="checkbox"/> Marriage*					
<input type="checkbox"/> Birth*					
<input type="checkbox"/> Stepchild*					
<input type="checkbox"/> Child legal Adoption*					
<input type="checkbox"/> Child legal Guardian*					
<input type="checkbox"/> Sponsored Dependent					
<input type="checkbox"/> Other					

REMOVE Members from Plan			
Event	Name (First & Last)	Event Date	Date of Birth
<input type="checkbox"/> Divorce*			
<input type="checkbox"/> Death			
<input type="checkbox"/> Loss of Dependency*			
<input type="checkbox"/> Other			

*COBRA Supplemental Information			
Under Federal law Oakland County is required to offer the opportunity to continue health coverage to members on your health plan who lose coverage for various reasons. Please complete this section with regard to the person(s) you are removing from your health plan so we may direct the required correspondence correctly.			
<input type="checkbox"/> Divorce	Former spouses Address:	City	State, Zip Code
<input type="checkbox"/> Remove a Child	Child(ren)s Address:	City	State, Zip Code

Other Changes				
<input type="checkbox"/> Name Change:	From:	To:	Effective:	Reason:
<input type="checkbox"/> Additional information:				

CONTINUE →

I certify the information provided on this form is true and correct to my knowledge and belief and understand improperly enrolling or continuing coverage for an ineligible member may result in recovery of improperly paid claims.	Date
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Retiree Signature _____

This Section for Office Use Only

COMMENTS:

Effective	Group Sig.	Group/Div
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Guidelines for Adding Members To Your Contract

MARRIAGE	You may complete & submit this form up to 30 days after the date of the marriage. You must submit a copy of your marriage license and spouse Social Security Card with this form. Coverage becomes effect the date of the marriage.
BIRTH OF CHILD	Report a birth within 30 days of the birth date. A copy of the birth certificate and Social Security Card is required with this form.
STEP CHILD	You may complete this form up to 30 days before or 30 days after the marriage. A copy of the birth certificate(s), child's Social Security Card and marriage license is required with this form.
CHILD BY LEGAL ADOPTION	Report within 30 days of the date of petition or date child takes up residence, whichever is later. A copy of the legal documentation and child's Social Security Card is required with this form.
CHILD BY LEGAL GUARDIANSHIP	Report within 30 days of the date of petition or date child takes up residence, whichever is later. A copy of the legal documentation and child's Social Security Card is required with this form.
OTHER	Use this area to request the addition of any other eligible dependent not listed above.

Guidelines for Removing Members To Your Contract

DIVORCE/ LEGAL SEPARATION	Include the name of the divorced spouse and date of divorce judgment OR legally separated spouse. Indicate if coverage for the child(ren) is to be continued on the subscriber's contract. Complete the "COBRA Supplement Information" section. Be sure to include the social security number and address of the divorced spouse in this section.
DEATH OF DEPENDENT	Give the name of the deceased dependent, date of death and a copy of the death certificate.
DEPENDENT MISC.	Use this form to remove dependents who are no longer meet eligibility requirements such as age, obtain other coverage, etc. and complete the "COBRA Supplement Information" section.
OTHER	Use this area to request the deletion of any other (or additional) dependent not covered above and complete the "COBRA Supplement Information" section.
ADDITIONAL INFORMATION	This section may be used for misc. information and to provide names, address, social security numbers and other information specifically requested in other areas of this form.

Coordination Of Benefits (COB) and Other Coverage Information

Is any member(s) enrolling in the County Retiree plan covered by any other health coverage? Yes <input type="checkbox"/> NO <input type="checkbox"/>	If yes, coverage provided by his/her employer Yes <input type="checkbox"/> NO <input type="checkbox"/>
Carriers Name:	Primary Cardholders Name:
Policy Number:	Type: Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>
Is any member enrolling in a County Retiree plan covered under COBRA? Yes <input type="checkbox"/> NO <input type="checkbox"/>	If yes, list COBRA effective date and attach a copy of the COBRA election form: Members name: _____
Is any member enrolling covered by Medicare Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D (Rx) <input type="checkbox"/> ?	If yes, do they have Medicare Supplement? Yes <input type="checkbox"/> NO <input type="checkbox"/> Carriers Name: _____
Is there a Court order for any child listed above that states which parent is responsible for providing health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, attach a copy of the Court order and indicate the following:	
1. Who is responsible for providing health care for the child(ren) listed above? Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/>	2. Who has physical custody of the child(ren) listed above? Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/>

Authorization For Release Of Protected Health Information

By signing below as a Retiree or dependent, I authorize the use or disclosure of my individually identifiable health information by or to any family members, any health care provider, the plan sponsor, the insurer/TPA of the plan or any other entity providing services in connection with the plan in order to process my enrollment in the plan or to process any claim for my plan benefits. This authorization is effective until the date I terminate enrollment in the plan. Further, I have read and understand the following: 1) I may revoke this authorization at any time before its expiration date by notifying the plan in writing, but the revocation will not have any effect on any actions the plan took before it received the revocation; 2) I may see and copy the information described on this authorization if I ask for it;
3) I am not required to sign this authorization to receive my health care benefits (enrollment, treatment or payment) and 4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Retiree Signature:	Date:
Spouse Signature:	Date:
Dependent Signature**:	Date:
Dependent Signature**:	Date:

**Children age 18 or older should sign on the "Dependent Signature" line. Minor children are not required to sign this form.