STATE OF OHIO

BENEFIT ENROLLMENT/CHANGE FORM

Use this form to select coverage, to change coverage, or to make changes to dependent information.

Instructions:

- You may print this form and complete it by hand or enter the information online, print, sign and return to your human resources office.
- Ensure that Section I, II, and III are completed in their entirety.
- If you are a bargaining unit employee and requesting dental/vision coverage through Union Benefits Trust (UBT) you must go to the UBT website at BenefitsTrust.org and complete their enrollment form or login to myOhio and complete your enrollment via self-service.
- Ensure that all dependents and their information are listed.
- You are required to submit documentation that verifies dependent eligibility when you initially enroll or have a change in status/qualifying event. Documentation requirements can be found on the DAS website DAS.Ohio.gov/Eligibility. The deadline for submitting your documentation is 31 days[1] after your date of hire or the date of your change in status/qualifying event. Your dependents are ineligible for benefit coverage until all required documentation has been submitted.

SECTION I – EMPLOYEE INFORMATION *(please print legibly)*

IMPORTANT: Your name and the name of your dependent(s) must match the name listed on the card issued by the Social Security Administration.

OHID Workforce User ID:	**Legal Last Name**	**Legal First Name**	**M.I.**

Home Address (Cannot be a P.O. Box)	**City**	**State**	**ZIP Code**	**County**
Mailing Address (Can be a P.O. Box)	**City**	**State**	**ZIP Code**	**County**

Phone (please include the area code) ☐ Home ☐ Mobile	**Work Phone**

SECTION II – ENROLLMENT INFORMATION

1. *Consult with your agency human resources office about change in status/qualifying event scenarios that offer an extended deadline.*

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Self-Enrolled: (Check all boxes that apply)

Medical PPO ☐Add ☐ Waive OR **Medical Select** ☐ Add ☐ Waive

Dental ☐Add ☐ Waive

Vision ☐Add ☐ Waive

Change in Status/Qualifying Events	
☐ New hire/Rehire	☐ Gain or loss of another employer coverage
☐ Birth/Adoption	☐ Exempt/Bargaining unit change[2] (dental/vision coverage only)
☐ Divorce/Marriage	☐ Dependent no longer meets eligibility requirements
	☐ Open Enrollment

Date of Qualifying Event[3]: _____

Legal Name and Social Security Number	**Dependent Type**	**Date of Birth**	**Gender**	**Plan (Check all boxes that apply)**
Spouse Last: _____ First: _____ SSN: _____	☐ Legal Spouse		☐ M ☐ F	Medical ☐ **Add** ☐ **Remove** Dental ☐ **Add** ☐ **Remove** Vision ☐ **Add** ☐ **Remove**

2. *Dental and vision options may differ for bargaining unit versus exempt employees.*

3. *If the Date of Change in Status/Qualifying Event is more than 31 days prior to today's date, an appeal form must accompany this submission. Please see your agency human resources office to obtain the appeal form.*

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NOTE: Effective 7/1/2024, eligibility criteria for dental/vision coverage for ages 19 through 25 has changed. The current criteria for these ages is that the dependent must be unmarried, a resident of Ohio, their current job does not offer dental/vision, they are not eligible for Medicaid or Medicare, or are a full-time student at an accredited school of higher education, if not a resident of Ohio.

Legal Name and Social Security Number	Dependent Type	Date of Birth	Gender	Marital Status	Plan (Check all boxes that apply)
Dependent Last: _____ First: _____ SSN: _____	☐ Child under age 26 ☐ Stepchild under age 26 ☐ Foster child under age 26 ☐ Legal Guardianship/Ward under age 26 ☐ Age 19 through 25 *for dental/vision coverage only* ☐ Disabled		☐ M ☐ F	☐ Single ☐ Married	Medical ☐ **Add** ☐ **Remove** Dental ☐ **Add** ☐ **Remove** Vision ☐ **Add** ☐ **Remove**
Dependent Last: _____ First: _____ SSN: _____	☐ Child under age 26 ☐ Stepchild under age 26 ☐ Foster child under age 26 ☐ Legal Guardianship/Ward under age 26 ☐ Age 19 through 25 *for dental/vision coverage only* ☐ Disabled		☐ M ☐F	☐ Single ☐ Married	Medical ☐ **Add** ☐ **Remove** Dental ☐ **Add** ☐ **Remove** Vision ☐ **Add** ☐ **Remove**
Dependent Last: _____ First: _____ SSN: _____	☐ Child under age 26 ☐ Stepchild under age 26 ☐ Foster child under age 26 ☐ Legal Guardianship/Ward under age 26 ☐ Age 19 through 25 *for dental/vision coverage only* ☐ Disabled		☐ M ☐ F	☐ Single ☐ Married	Medical ☐**Add** ☐ **Remove** Dental ☐**Add** ☐ **Remove** Vision ☐**Add** ☐ **Remove**

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Legal Name and Social Security Number	Dependent Type	Date of Birth	Gender	Marital Status	Plan (Check all boxes that apply)
Dependent Last: _____ First: _____ SSN: _____	☐ Child under age 26 ☐ Stepchild under age 26 ☐ Foster child under age 26 ☐ Legal Guardianship/Ward under age 26 ☐ Age 19 through 25 *for dental/vision coverage only* ☐ Disabled		☐ M ☐ F	☐ Single ☐ Married	Medical ☐ **Add** ☐ **Remove** Dental ☐ **Add** ☐ **Remove** Vision ☐ **Add** ☐ **Remove**
Dependent Last: _____ First: _____ SSN: _____	☐ Child under age 26 ☐ Stepchild under age 26 ☐ Foster child under age 26 ☐ Legal Guardianship/Ward under age 26 ☐ Age 19 through 25 *for dental/vision coverage only* ☐ Disabled		☐ M ☐ F	☐ Single ☐ Married	Medical ☐ **Add** ☐ **Remove** Dental ☐ **Add** ☐ **Remove** Vision ☐ **Add** ☐ **Remove**

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Terms and Conditions:

1. I have read the provisions of dependent eligibility. Specifically, I have read and agree to the dependent eligibility rules that can be accessed DAS.Ohio.gov/Benefits. Further, by submitting my benefit choices, I certify that the dependent(s) under my coverage comply with these eligibility rules. Importantly, I understand that enrolling an ineligible dependent(s) may be considered fraud and could result in disciplinary action up to and including removal. In addition, my employer may decide to initiate court or collections action for any fraudulently paid monies.

   I understand that I may be subject to an eligibility audit during any benefit year in which I am enrolled for benefits coverage. I may also be required to supply documentation such as certified birth certificate(s), marriage certificate(s), or other documentation related to the eligibility of my dependents. Finally, I understand that if it is found that I have fraudulently obtained benefit coverage for a dependent, I may be held financially liable by the provider for the cost of any claims paid for that dependent. If enrolling for coverage, which I understand is voluntary, I authorize the deduction from my paycheck for the cost of coverage which I have elected. I understand that payment on a pre-tax basis means that my gross pay will be reduced by the cost of the coverage before any applicable taxes are deducted.

   I acknowledge that the information on this Benefit Enrollment/Change Form is complete and accurate. I understand that the information provided on this Form will be used to determine eligibility for coverage. Incomplete/inaccurate information could provide the basis to refuse or revoke coverage and may result in disciplinary action up to and including removal.

2. If waiving health insurance coverage at this time, I understand I will have to wait until the next open enrollment period in order to enroll in any of the Plans, unless I have a change in status/qualifying event. If I experience a change in status/qualifying event, I must complete and submit the Benefit Enrollment/Change Form within 31 days of the change in status/qualifying event and provide applicable supporting documentation.

3. I cannot start, stop, or change any pretax election until the next open enrollment unless I experience a change in status/qualifying event. If I experience a change in status/qualifying event, I must complete and submit the Benefit Enrollment/Change Form within 31 days of the change in status/qualifying event and provide applicable supporting documentation.

4. Any change made in anticipation of a qualifying event will not be allowed. No dependents can be added or dropped from coverage until the qualifying event has occurred.

5. I acknowledge the requirement that my and my dependent's Social Security numbers may be used as identifiers, as required under the Health Insurance Portability and Accountability Act (HIPAA). Social Security numbers are required for all dependents.

6. Unless otherwise prevented by law, I authorize, for myself and my dependents, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information to the insurance provider or its authorized representatives. Furthermore, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances in relation to health benefit coverage and care.

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- You are responsible for enrolling/disenrolling a dependent that becomes eligible/ineligible under the plan provisions.
- You must notify your agency's benefits representative and submit the required documentation within 31 calendar days of the change in status/qualifying event.[4]
- Please review the "Required Documents Worksheet for Adding and Maintaining Dependents" and "Required Documents for Disenrolling Dependents" and confirm your dependents are eligible or not eligible for coverage by completion of this form and the submission of the required documents.
- **Please return the completed form with all required documents to your agency human resources office.**

By signing this form, I attest that I have reviewed the Dependent Eligibility Definitions found at DAS.Ohio.gov/Benefits and that the information I am submitting is true and accurate.

Signature: _____ Date: _____

LATE DOCUMENTATION RULES

If you are unable to obtain certain documents (e.g., marriage certificate) within the required 31-day deadline, you should still initiate the enrollment/disenrollment process without submitting all the required documentation. See the requirements below for submission of late documentation -- if you do not meet these requirements your coverage change request will be denied. **Please note: The coverage change will not be processed until all forms and proof of eligibility are received and approved.**

☐ You must *initiate* the enrollment/disenrollment process by submitting a completed Benefit Enrollment/Change Form and as much documentation as possible within 31 days of the initial enrollment or change in status/qualifying event; **and**

☐ You must provide a valid reason with your submission as to why documentation is missing, along with an estimated date when it will be available; **and**

☐ You must submit the required missing documentation no later than 60 days after the date you initially enroll or have a change in status/qualifying event.

If you believe this situation applies to you, please include the name of the delayed document, reason for the delay and an estimated date of when the document will be available below. If your initial enrollment or change in status/qualifying event is denied, talk to your agency human resources office about your options for an appeal.

Missing Document: _____ *Estimated date of submission:* _____

*Reason:*_____

4. *Dental and vision options may differ for bargaining unit versus exempt employees.*