MedBen health. benefits.

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WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

MUSKINGUM UNIVERSITY EMPLOYEE APPLICATION

For Office Use Only **Group No. 10552** **Effective Date**_____ **COBRA Election Date**_____ **ML-01**

❶ **Employee Information (Please Print in Ink):**

Social Security Number

Name _____
Last First Middle Initial

Home Address_____ Telephone (___)_____Email Address:_____
Street / P.O. Box City State Zip

Employee Date of Birth	**Sex**	**Marital Status**	**Date Hired**	**Hours Worked Weekly**	**Location Selection**
___/___/__ Mo Day Yr	❑ Male ❑ Female	❑ Single ❑ Divorced ❑ Married ❑ Widowed	___/___/__ Mo Day Yr	_____	❑ Active Employees – Location 1 ❑ Retiree – Location 2

Medical/Rx Election *(Please select only 1 option)*	**Medical/Rx Plan Election** *(Please select only 1 option)*	**Dental** *(COBRA Purposes Only)* *(Please select only 1 option)*	**Vision** *(COBRA Purposes Only)* *(Please select only 1 option)*
❑ Employee Only ❑ Employee / Spouse ❑ Employee / Child(ren) ❑ Family	❑ Plan Option I – Account 1 ❑ Plan Option II – Account 11	❑ Employee Only ❑ Employee / Spouse ❑ Employee / Child(ren) ❑ Family	❑ Employee Only ❑ Employee / Spouse ❑ Employee / Child(ren) ❑ Family

❷

IF APPLYING FOR DEPENDENT COVERAGE LIST BELOW
If you do not wish to cover your eligible dependents, please complete the waiver in section 3

Full Name	Date of Birth	SSN or HIC# (if Medicare eligible)	Sex		Email Address	Employed Elsewhere? Y/N	Eligible for other coverage? Y/N					
			Male	Female								
Spouse												
Other Dependent(s)						Employed Elsewhere? Y/N	Eligible for other coverage? Y/N	Natural Child	Adopted Child*	Step-Child	Legal Custody Guardian*	Fulltime Student?

**Please attach to this application copies of the court orders or legal documents creating this relationship. For adopted children, only necessary for initial enrollment after adoption or placement.*

1.) Spouse employed? ❑ Yes ❑ No Employed By _____ Date of Marriage_____

2.) Are you covered or insured under any other medical coverage (including Medicare and other government plans)? If "Yes", Please indicate who the carrier is below:

Medical ❑ Yes ❑ No Carrier _____

3.) Are your spouse or children covered or insured under any other medical coverage (including Medicare and other government plans)? If "Yes", Please indicate who is covered under this other coverage, and who the carrier is below:

Medical ❑ Yes ❑ No Carrier _____Names of those Covered_____

4.) Are any of the Dependents listed above in the legal custody of another Person? ❑ Yes ❑ No If "Yes", please submit documentation.

❸

WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within the time period required by your plan (30 or 31 days - see plan document) after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within the time limit allowed by your plan after the date of the marriage, birth, adoption, or placement for adoption. Your plan may also allow additional enrollment periods as specified in the plan document. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described, if you fail to enroll at this time you may not be eligible to enroll thereafter, or may be subject to certain restrictions which are described in your plan.

I waive coverage for: ❑ All Medical/Rx ❑ Spouse Medical/Rx ❑ Child(ren) Medical/Rx ❑ Family Medical/Rx

Employee Signature_____ **Date**_____

Are you waiving the coverage listed above because you and/or your dependents have other health coverage? ❑ Yes ❑ No With whom? _____

_____

❹

Read this Statement and Authorization Carefully

I hereby request health care coverage and/or insurance and authorize that any requested contribution for the coverage and/or insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide MedBen or its legal representative any information in its possession which is relevant to this application for coverage and/or insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligiblity for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of MedBen with responsibility for (1) reviewing applications and determining eligiblity for coverage and/or insurance, (2) process and/or payment of claims, and (3) any health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers, stop loss carriers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). This authorization is effective on the date signed and shall remain in effect until the date such coverage and/or insurance is terminated. (You, or any individual authorized by law to act on your behalf, have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage and/or insurance. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer at MedBen at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for recission or cancellation of the coverage and/or insurance for me and my Dependent(s), if any.

Employee Signature _____ Date _____

I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.