**City of Hollywood, Florida**
**Employee Group Medical and Dental Plan**

__New Enrollment __Reinstate
__Open Enrollment __Change

**OFFICE USE ONLY**
Effective Date of Coverage:_____/_____/______ Medical Code:______ Dental Code:______ Classification:_____________________

**Subscriber Information**

| Employee Last Name | First Name | M.I. | Social Security Number* | Date of Birth | Gender __M __F |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address | Apt. | City | State | Zip | County |
|---|---|---|---|---|---|
| | | | | | |

| Department/Division | Job Title | Date of Hire | Work Phone (if any) and Home Phone ( )____-______, ( )____-______ |
|---|---|---|---|
| | | | |

**If this is a Change, Indicate Type:** __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof)
__New address(as above), __New Name: From___________________________________ to ________________________________________
**This Change is due to:** ___Marriage ___Birth ___Separation of Employment ___Other:__________________ Date of Event:_______________

**Additional Information**

Have you had continuous health care coverage for the past 12 months?__Yes __No
If yes, please attach a copy of your certificate of coverage as evidence of prior coverage.

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date?Yes __No Dental? __Yes __No
If yes, list Covered Person(s):_______________________________________________________________**Attach copy of ID Card(s)**
Insurance Company Name:______________________________________ Do you or your spouse have Medicare?__Yes __No

| **Covered Individuals** | **Medical** | | **Comprehensive Dental** | | **Premium Dental** | |
|---|---|---|---|---|---|---|
| **Indicate your medical and/or dental coverage options by placing an X in the appropriate ( )** | **Indicate Option** | **OFFICE USE ONLY** | **Indicate Option** | **OFFICE USE ONLY** | **Indicate Option** | **OFFICE USE ONLY** |
| Employee Only | ( ) | | ( ) | **111** | ( ) | **114** |
| Employee and One Dependent* | ( ) | | ( ) | **112** | ( ) | **115** |
| Employee and Two or More Dependents* | ( ) | | ( ) | **113** | ( ) | **116** |

*Eligible dependents are: spouse or domestic partner and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medical or dental plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or change.

| **Last Name** **First** **M.I.** | **Date of Birth** | **Gender** | **Social Security Number*** | **Coverage Selection** |
|---|---|---|---|---|
| (2) ___Spouse or ___Domestic Partner | MM-DD-YY | ___M<br>___F | | ___Add Medical ___Drop Medical<br>___Add Dental ___Drop Dental |
| (3) Dependent | MM-DD-YY | ___M<br>___F | | ___Add Medical ___Drop Medical<br>___Add Dental ___Drop Dental |
| (4) Dependent | MM-DD-YY | ___M<br>___F | | ___Add Medical ___Drop Medical<br>___Add Dental ___Drop Dental |
| (5) Dependent | MM-DD-YY | ___M<br>___F | | ___Add Medical ___Drop Medical<br>___Add Dental ___Drop Dental |
| (6) Dependent | MM-DD-YY | ___M<br>___F | | ___Add Medical ___Drop Medical<br>___Add Dental ___Drop Dental |

Proper documents required: marriage/domestic partner certificate, birth certificate, hospital birth record, adoption award, medical child support order.

**Authorization**

I hereby (1) **REQUEST** coverage for the Group Medical and/or Dental Plan for which I am, or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made direc the hospital or physician for services rendered unless paid receipts are presented. *Your social security number is requested for the purpose of payroll eligibility verification, processing employment benefits, applicant and employee background checks, and income reporting. In addition, the social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

**Employee Signature** _________________________________ **Date**____________________

**Declination**

I hereby **DECLINE** ___Medical and/or___Dental coverage at this time. I realize that I cannot elect coverage until the next enrollment period unless I have a qualifying event as allowed in the Plan Document.

**Employee Signature** _________________________________ **Date**____________________

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