



York County Government Benefits Enrollment Form

Use this form to enroll or to make changes to your Medical, Vision, Prescription and Dental Plans

Please Print Clearly

Please indicate the change:

- New Enrollment
- Add Dependand(s)
- Remove Dependand(s)
- Name Change
- Address Change
- Cancel Coverage
- Other _____

Effective Date: _____

- Waive Coverage

Section 1: Employee Information:

Employee ID (5 Digits):	Dept.:	Hire Date:
Full Name (Last, First MI):		
Social Security #:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:
Address:		
City:	State:	Zip Code: Phone:

Section 2: Coverage Information:

Level of Coverage	PPO (Medical, Prescription & Vision) (Choose one option only)		Dental (Choose one option only)	
	Preferred Plus	Preferred*	Basic Option <input type="checkbox"/>	High Option <input type="checkbox"/>
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee + 2 or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Available to: Non-Bargaining, PSSU Probation & DR, AFSCME, Court Related & Court Appointed Only*

Section 3: Dependent Information: Complete only if dependent coverage is elected.

Full Name (Last, First, MI)	Relationship (Spouse/ Children)	Birth Date	Gender (M/F)	Social Security #	Disabled	Medical, Vision & Rx	Dental
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Office Use Only

Health Group : _____
 Prescription Group : _____
 Vision Group : 1106- _____
 Dental Group : _____

MEMO : _____



MEDICARE COVERAGE INFORMATION

(IF YOU OR YOUR DEPENDENT ARE CURRENTLY COVERED BY MEDICARE, COMPLETE THE FOLLOWING)

Medicare Recipient	Health Insurance Claim #	Effective Date(s)		Reason for Medicare Entitlement (check one):
		Part A (Hospital) Mo/Day/Year	Part B (Medical) Mo/Day/Year	
		/ /	/ /	<input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> End State Renal Disease
		/ /	/ /	<input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> End State Renal Disease

OTHER INSURANCE INFORMATION

Are any of your children required to be covered under any other Medical Plan by provisions of a Court or Domestic Relations order?

 Yes
 No

If 'YES', please explain: _____

Are you, your spouse, or any of your children covered under any OTHER Medical Plan?

 Yes No

If 'YES', please complete the following:

Participant	Name of Plan	Coverage Provided	Policy #

EMPLOYEE AUTHORIZATIONEMPLOYEE ONLY AND/OR EMPLOYEE PLUS DEPENDENT COVERAGE

I hereby authorize my employer to make salary reductions to be contributed by the Company to the Plan for the cost of my employee plus any above listed dependent (s) health care benefits. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease. I understand that this agreement will remain in effect until I notify my Employer in writing of any changes (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation of an election).

I hereby certify that any Dependents enrolled are my dependents as defined in the Summary Plan Description. I agree to notify the Plan Administrator of any changes in status of any dependent or of any additional dependents I may acquire. I have read and understand the below information regarding social security number privacy rights.

Employee Signature _____ Date _____

TO DECLINE COVERAGE

I understand that I, as the employee and my dependents (if applicable), are eligible for benefits under the Group Health Plan. I certify that benefits under such Plan have been explained to me in detail. After careful consideration, I/We decline coverage under such Plan because I/We are covered under another Health Insurance Plan and waive all claims to benefits under this Plan. I have read and understand the below information regarding social security number privacy rights.

Employee Signature _____ Date _____

**** NOTE: YOU ARE BEING ASKED TO PROVIDE YOUR SOCIAL SECURITY NUMBER AND THE SOCIAL SECURITY NUMBER(S) OF ANY ELIGIBLE AND ENROLLED DEPENDENTS FOR PURPOSES OF IDENTIFICATION WITH THE INSURANCE CARRIERS. THIS INFORMATION WILL NOT BE USED FOR ANY OTHER PURPOSE. SHOULD YOU WISH NOT TO DISCLOSE THIS INFORMATION, PLEASE CONTACT THE HUMAN RESOURCES DEPARTMENT.**