5721

**Effective Date of Coverage**

/ /

**Hire Date**

/ /

Group **CITY OF CHARLESTON**

**BENEFIT PLAN ENROLLMENT CARD**

|  |  |  |
| --- | --- | --- |
|  |  |  |

Location Dental Loc. Department

Ο-Active Ο-Retiree Ο-Widow

**Employee Information Department**

Name

**(First) (Middle) (Last) Social Security Number**

Address

**Street City State Zip Code**

Date of Birth:\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Ο-Single Ο-Married Ο-Widowed

Ο-Divorced Ο-Separated

**MEDICAL DENTAL/VISION**

**DENTAL PLAN OPTION**

Ο Standard

Ο Enhanced

Ο elect single Ο elect single

Sex

O Male

O Female

Ο elect employee + one child Ο elect employee + one child

Ο elect employee + spouse Ο elect employee + spouse

Ο elect employee + children Ο elect employee + children

Ο elect family Ο elect family

Ο do no elect coverage Ο do no elect coverage

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Names of Dependents To Be Covered:** | | | | | | | | | |
| **Name** | | **Social Security Number** | | | **Relationship** | **Sex M/F** | **Birthdate** | **Full Time**  **Student Y/N** | **Handicapped Y/N** |
|  | |  |  |  |  |  |  |  |  |
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| **ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE** | | | | | | | | | |
| Do you or any of your dependents have other health coverage? Yes No If "YES", complete the following boxes | | | | | | | | | |
| Name(s) of Covered Persons | Name of Other Insurance Co. | | Policy Number | | Effective Date/Cancel Date | | Coverage Type(s) | | |
|  |  | |  | |  | | Ο Medical Ο Prescription Drug  Ο Dental Ο Vision | | |
|  |  | |  | |  | |
|  |  | |  | |  | |  | | |
|  |  | |  | |  | |
| **Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.**  \***Check box below for each individual receiving treatment for end-stage renal disease.** | | | | | | | | | |
| Ο-You Medicare# Eff. Date - Part A: Part B: | | | | | | | |  | **Renal Disease**  **Renal Disease Renal Disease** |
| Ο-Spouse Medicare# Eff. Date - Part A: Part B: | | | | | | | |  |
| Ο-Dependent Medicare# Eff. Date - Part A: Part B: | | | | | | | |  |
| **Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.**  1. Dependent City & State 2. Dependent City & State | | | | | | | | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee Signature Date

(Please check other side)

**Healthcare Premium Discount Enrollment Verification**

**Overview & Instructions:** The City of Charleston offers eligible full-time employees a Health Risk Management (HRM) or Non-Tobacco User (NTU) healthcare premium discount. In order to receive the HRM or NTU discount eligible employees must enroll and comply with the HRM or NTU program discount requirements. A complete description of each discount can be found in Section I. Please review each description and select the box adjacent to the premium for which you would like to enroll. If you enroll in the City's healthcare plan, **you must select one (1) box in Section I.** Complete Section II in its entirety, and sign and date the enrollment form in Section III.

# Section I. Healthcare Premium Selection (Please Select only 1 Box)

**Standard Rate**: Select this option if you do not want to enroll in the Health Risk Management (HRM) Program or receive the Non-Tobacco User discount.

**Health Risk Management (HRM) Discount:** The City has partnered with CareHere, the operator the City of Charleston Employee Wellness Center and the Pharm UC Patient Care Clinic at the University of Charleston to offer an HRM Program to eligible employees. To participate in the HRM Program and be

eligible to receive a discounted healthcare premium, you must certify and agree that you and your covered spouse, if applicable, will adhere to the program requirements including, but not limited to keeping appointments with Wellness Center and/or Pharm UC staff, complying with any program(s) prescribed

by Wellness Center and/or Pharm UC medical professionals and agree to participate in random nicotine screenings.

**Non-Tobacco User (NTU) Discount:** Select this option if you do not want to participate in the HRM Program, but would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products, and that you agree to participate in random nicotine screenings.

# Section II. Employee Information (Please Print)

Name: Department:

**Section III. Certification**

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge. I further understand that by enrolling in the HRM Program or electing to receive the NTU discount, by checking the designated box in Section I herein, that I agree to the applicable requirements in order to receive the associated discount. I also acknowledge and understand the City or its authorized agent may access my medical records for purposes of verifying my status as a tobacco user.

Employee Signature Date