

180950 -

Group

CITY OF CHARLESTON
BENEFIT PLAN ENROLLMENT CARD

Effective Date of Coverage
Hire Date
Department

Location Dental Loc. Department

O-Active O-Retiree O-Widow

Employee Information

Name (First) (Middle) (Last)

Social Security Number

Address Street City State Zip Code

Date of Birth:

Marital Status:

- O-Single O-Married
O-Widowed
O-Divorced O-Separated

Telephone Number:

- MEDICAL: elect single, elect employee + one child, elect employee + spouse, elect employee + children, elect family, do no elect coverage
DENTAL/VISION: elect single, elect family, do no elect coverage
DENTAL/VISION PLAN OPTION: Standard, Enhanced

Table with 7 columns: Name, Social Security Number, Relationship, Sex M/F, Birthdate, Full Time Student Y/N, Handicapped Y/N. Title: Names of Dependents To Be Covered:

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

Table with 4 columns: Name(s) of Covered Persons, Name of Other Insurance Co., Policy Number, Effective Date/Cancel Date. Coverage Type(s): O Medical, O Prescription Drug, O Dental, O 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.

Table with 5 columns: O-You, Medicare#, Eff. Date - Part A, Part B, Renal Disease. O-Spouse, Medicare#, Eff. Date - Part A, Part B, Renal Disease. O-Dependent, Medicare#, Eff. Date - Part A, Part B, Renal Disease

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