UnitedHealthcare
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2018 HEALTH CARE ELIGIBILITY AND ENROLLMENT FORM

If you or your qualified dependents **are non-Medicare eligible, early Medicare, Medicare A only, Medicare B only, or residing outside of the U.S.** complete and return this form to UnitedHealthcare Insurance Company (UnitedHealthcare) to enroll, re-enroll, or waive yourself and your qualified dependents in the OP&F-sponsored health care plan if you are a new benefit recipient or if you have met a qualification for re-enrollment.

If you or your qualified dependents are **age 65 and over, Medicare eligible and enrolled in Medicare Parts A and B**, you will be eligible to enroll in an OP&F-sponsored AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents). Please call (800) 545-1797 for additional information. You will, however, be required to complete and return this form to UnitedHealthcare to enroll, re-enroll or waive yourself or your qualified dependents in the OP&F-sponsored health care and/or prescription drug coverage if you are a new benefit recipient or if you have met a qualification for re-enrollment.

UnitedHealthcare must receive this form within 60 days of the qualifying eligibility event or within 60 days of receiving your interim benefit payment in order for your request to be valid. If this form is not received within 60 days of the qualifying event, your request for enrollment will be denied and you will have very limited opportunities to re-enroll. Please refer to the *Members' Guide to Health Care Coverage for 2018* for detailed eligibility guidelines and re-enrollment opportunities.

- ☐ I am, or will soon retire and become a new benefit recipient.
- ☐ I have met a qualification for re-enrollment in the OP&F-sponsored health care plan below.
  - ☐ Three years after OP&F retirement or commencement of benefits (member or survivor only)
  - ☐ Change in family status - *Please provide proof of the change (ie. adoption papers, marriage certificate, divorce decree)*
  - ☐ Involuntary loss of group coverage - *Please provide proof of loss including the termination date of the coverage and all dependents covered.* (i.e., Medicaid, COBRA, employer coverage)
  - ☐ Medicare eligibility - *Please provide a copy of the Medicare card*
  - ☐ Proof of eligibility in CHIP/Children's Medicaid Program - *Please provide a copy of the Medicaid card*

Section A — Member information

Name: First, MI, Last, Suffix (Jr., III, etc.) ☐ Police Officer ☐ Fire Fighter

Social Security Number

Street / P.O. Box ☐ New address

Date of Birth

City, State, ZIP Code

Gender: ☐ Male ☐ Female

Home telephone	Alternate telephone	E-mail address

Marital status (Do not mark single if you are divorced)

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Marriage date	Divorce date

It is extremely important that you and your dependents enroll in Medicare when you become first eligible. If you or your enrolled dependents fail to enroll in Medicare Parts A or B when you are first eligible, the OP&F–sponsored plan requires UnitedHealthcare to process claims as if you or your dependent were Medicare eligible and you will be responsible for all fees and expenses incurred that Medicare would have paid. In addition, OP&F reserves the right to recover any reimbursements erroneously processed for these individuals by UnitedHealthcare.

☐ Yes ☐ No Are you eligible for Medicare?
If yes, please attach a copy of your Medicare card when returning this form.

☐ Yes ☐ No Aside from OP&F, is any other entity reimbursing you for your Medicare Part B premium?
If yes, who? _____

☐ Yes ☐ No Are you or any dependents enrolled in Medicare Part D drug coverage? If yes, please list their names and effective enrollment dates: _____
Please attach proof of effective date.

☐ Yes ☐ No Have you ever terminated Medicare Part D? If yes, please list the date of termination: _____
Please provide a copy of your disenrollment letter.

☐ Yes ☐ No Are you eligible for Medicaid?
If yes, please attach a copy of your Medicaid card when returning this form.

Section B — Dependent information

Please complete this section by listing your dependents that are eligible to participate in the OP&F–sponsored health care plan. You must attach a copy of all supporting documentation, such as a birth certificate, marriage certificate, or Medicare card, to this form and return it to UnitedHealthcare in the enclosed envelope. **Listing a dependent on this form does not automatically entitle them to coverage. A completed *Dependent Child(ren) Coverage Application* is also required for dependent children ages 18-26. Overage dependent verification is done annually and there will be another form to fill out during Annual Change Period.** For more information, see the *Members' Guide to Health Care Coverage for 2018.*

To enroll your dependents in any coverage, such as health care or prescription drug, you must also be enrolled in that plan. In addition, UnitedHealthcare may not be able to process a waiver of coverage for a dependent if contrary to the terms of an existing court order that prohibits you from removing a dependent from this coverage.

Dependent Name	Social Security number	Date of birth	Gender	Relationship	Eligibility status	Enroll in coverage
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other: ________	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated	☐ Health Care ☐ Prescription drug ☐ UHC Dental ☐ UHC Vision
			☐ Male ☐ Female	☐ Child ☐ Other: ________	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated	☐ Health Care ☐ Prescription drug ☐ UHC Dental ☐ UHC Vision
			☐ Male ☐ Female	☐ Child ☐ Other: ________	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated	☐ Health Care ☐ Prescription drug ☐ UHC Dental ☐ UHC Vision
			☐ Male ☐ Female	☐ Child ☐ Other: ________	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated	☐ Health Care ☐ Prescription drug ☐ UHC Dental ☐ UHC Vision
			☐ Male ☐ Female	☐ Child ☐ Other: ________	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated	☐ Health Care ☐ Prescription drug ☐ UHC Dental ☐ UHC Vision

* If enrolled in Medicare or Medicaid, you must attach a copy of the dependent's Medicare and/or Medicaid card.

Section C — Enrollment selections

Please select your enrollment coverage below. **If you waive coverage for yourself or your dependents, you will have limited opportunities to enroll yourself or your dependents at a later time.**

Health care coverage	☐ **Enroll** me and my selected dependents in health care coverage. Effective date: ___________ ☐ **Waive** health care coverage for me and my dependents. Effective date: ___________
Prescription drug coverage	☐ **Enroll** me and my selected dependents in prescription drug coverage. Effective date: _________ ☐ **Waive** prescription drug coverage for me and my dependents. Effective date: ___________
Voluntary dental	☐ **Enroll** me and my selected dependents in voluntary dental coverage. Effective date: _________ ☐ **Waive*** voluntary dental coverage for me and my dependents. Effective date: ___________
Voluntary vision	☐ **Enroll** me and my selected dependents in voluntary vision coverage. Effective date: __________ ☐ **Waive*** voluntary vision coverage for me and my dependents. Effective date: ___________
Coverage start date	☐ My effective date of retirement ☐ Effective date of my qualifying event ☐ First day of the month following my effective date of retirement or qualifying event

* Enrollment requires the participant to stay in the plan until the end of the calendar year that you are enrolled.

Section D — Access to other group coverage

If you or your dependents are eligible for **any** other group coverage including employer and retirement coverage, you will not be eligible for enrollment in any of the OP&F sponsored health care plans. **If you are not yet drawing an OP&F pension check, please fill out this form using the employment status and insurance you will have after retirement.**

Benefit recipient

☐ Yes ☐ No Are you currently employed? If yes, please complete the following.

Employer name	

☐ Yes ☐ No Are you currently retired through another system other than Ohio Police and Fire? If yes, please complete the following.

Employer/Retiree-sponsored plan name	

☐ Yes ☐ No Are you offered employer/retiree sponsored health care coverage other than through Ohio Police & Fire?

Effective Date of Coverage	
Coverage offered	☐ Medical ☐ Prescription ☐ Dental ☐ Vision
Covered dependents	

Spouse

☐ Yes ☐ No Is your spouse currently employed? If yes, please complete the following.

Employer name	

☐ Yes ☐ No Is your spouse currently retired? If yes, please complete the following.

Employer/Retiree-sponsored plan name	

☐ Yes ☐ No Is your spouse offered employer/retiree-sponsored health care coverage?

Effective Date of Coverage	
Coverage offered	☐ Medical ☐ Prescription ☐ Dental ☐ Vision
Covered dependents	

Section E — Workers' compensation information

Workers' compensation (WC) refers to any health care claim that you or your dependent filed due to an accident, injury or disease while employed. If a benefit recipient or dependent agrees upon a lump sum medical supplement through worker's compensation, future claims relating to that occupational injury or illness will not be covered by either worker's compensation or the OP&F-sponsored health care plan.

☐ Yes ☐ No Have you or one of your covered dependents ever filed for WC?
If yes, who? _____ .

☐ Yes ☐ No Have you or one of your covered dependents entered into a lump sum monetary settlement with WC?
If yes, who? _____ .

Section F — Other Ohio retirement system benefits

☐ Yes ☐ No Do you receive a pension from any other Ohio retirement system?
If yes, please mark which Ohio retirement system. Start Date _____
- ☐ Ohio Public Employees Retirement System (OPERS)
- ☐ Ohio State Highway Patrol Retirement System (OSHPRS)
- ☐ School Employees Retirement System (SERS)
- ☐ State Teachers Retirement System (STRS)

☐ Yes ☐ No Do you receive an annuity with no other benefits?
If yes, please indicate which system on the above list.

☐ Yes ☐ No Does your spouse (listed in Section B) receive a pension from any other Ohio retirement system?
If yes, please mark which Ohio retirement system. Start Date _____
- ☐ Ohio Public Employees Retirement System (OPERS)
- ☐ Ohio State Highway Patrol Retirement System (OSHPRS)
- ☐ School Employees Retirement System (SERS)
- ☐ State Teachers Retirement System (STRS)

☐ Yes ☐ No Does your spouse receive an annuity with no other benefits?
If yes, please indicate which system on the above list.

Section G — Signature and Acknowledgement

You must sign and timely file this form with UnitedHealthcare if you have corrections, changes or need to update your information on file.

To the extent that this Section is signed and timely filed with UnitedHealthcare, I represent to UnitedHealthcare that all the information shown herein or provided by me is true and complete, including any information provided for purposes of filing for the Health Care and Prescription Drug Coverage Discount Program and that no information has been omitted. I further agree that UnitedHealthcare is entitled to recover all losses incurred by OP&F resulting from the foregoing representation being incorrect or incomplete along with any losses incurred by OP&F relating to the failure to comply with the health care plan requirements or to timely provide requested information or documentation on behalf of myself or my covered person(s) and that any mis-statement, misrepresentation or omission may impact my ability to participate in the health care plan sponsored by OP&F.

In all events, the coverages selected herein and the corresponding deduction of contributions from my benefit payments shall continue (subject to changes in the program, coverages, and contributions, as established by the Board of Trustees or Third Party Administrators from time to time) until I have waived my coverage and if my contributions exceed my benefit payment, OP&F must be reimbursed any difference or risk termination of coverage. If waiving coverage, I acknowledge the limited opportunities to re–enroll in the plan.

Benefit recipient's signature* ▶	Date of signature

* If you are signing as a power of attorney (POA), UnitedHealthcare requires a copy of the POA papers and will review them to ensure UnitedHealthcare can accept it for the processing of this form.