Niagara County
First Choice Health Coverage Enrollment/Waiver Worksheet

EMPLOYEE INFORMATION (If making a life status change, proof of change must be submitted.)

Name:____

Address:____
Street *City* *State* *Zip*

Coverage Effective Date:________________ Social Security #:________________________

Date of Birth:______________________ Phone #:________________________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Other ________________(indicate status)

☐ Union________________(indicate union affiliation) ☐ Non-Union

Status: ☐ New Hire____________ (Date) ☐ Status Change____________ (Date) ☐ Qualifying Event____________ (Date)

HEALTH COVERAGE (check applicable coverage level and plan election)

Health Plan Coverage Level	Health Plan Election
☐ Employee Only ☐ Family	☐ First Choice

Employee Primary Care Physician Name:____________________________________

DEPENDENT INFORMATION
Gender: ☐ Male ☐ Female
Relationship:________________
☐ Permanently Disabled

☐ Add Dependent **☐ Remove Dependent**
Name: ____
Address____
☐ address same as employee
Date of Birth:________________ SSN:________________
Dependent Primary Care Physician:________________________
(Please provide full name of primary care physician)

DEPENDENT INFORMATION
Gender: ☐ Male ☐Female
Relationship:________________
☐ Permanently Disabled

☐ Add Dependent **☐ Remove Dependent**
Name: ____
Address____
☐ address same as employee
Date of Birth:________________ SSN:________________
Dependent Primary Care Physician:________________________
(Please provide full name of primary care physician)

DEPENDENT INFORMATION
Gender: ☐ Male ☐Female
Relationship:________________
☐ Permanently Disabled

☐ Add Dependent **☐ Remove Dependent**
Name: ____
Address____
☐ address same as employee
Date of Birth:________________ SSN:________________
Dependent Primary Care Physician:________________________
(Please provide full name of primary care physician)

DEPENDENT INFORMATION
Gender: ☐ Male ☐Female
Relationship:________________
☐ Disabled

☐ Add Dependent **☐ Remove Dependent**
Name: ____
Address____
☐ address same as employee
Date of Birth:________________ SSN:________________
Dependent Primary Care Physician:________________________
(Please provide full name of primary care physician)

DEPENDENT INFORMATION ☐ **Add Dependent** ☐ **Remove Dependent**

Gender: ☐ Male ☐Female Name: _____

Address_____

Relationship:_____ ☐ address same as employee

☐ Permanently Disabled Date of Birth:_____ SSN:_____

Dependent Primary Care Physician:_____

(Please provide full name of primary care physician)

DEPENDENT INFORMATION ☐ **Add Dependent** ☐ **Remove Dependent**

Gender: ☐ Male ☐Female Name: _____

Address_____

Relationship:_____ ☐ address same as employee

☐ Permanently Disabled Date of Birth:_____ SSN:_____

Dependent Primary Care Physician:_____

(Please provide full name of primary care physician)

HEALTH COVERAGE BENEFIT WAIVER

1. Are you or any dependents covered by another group health plan? _____Yes _____No
2. Name of the individual with other coverage:_____
3. Name of insurance carrier or third party administrator (TPA):_____
4. Address:_____
5. Name of other employer providing coverage:_____
6. Is Medicare/Medicaid applicable? _____Yes _____No

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HEALTH COVERAGE WAIVER STATEMENT: (If you have DECLINED any coverage or benefits, please answer the following question):

Are you declining health coverage due to enrollment in another plan? _____Yes _____No

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IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your eligible dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to be eligible to enroll at a later date under the special enrollment rules. In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You and/or your dependents have the right to demonstrate credible coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, your employer will assist you in obtaining this certificate.

PREMIUM PAYMENT PLAN/ DEPENDENT COVERAGE ELIGIBILITY

I acknowledge, by signing this form, that health coverage contributions are deducted from my paycheck. I also understand that I can not change my benefit election or enrollment options until the next open enrollment period, unless I have a change in family status such as marriage, divorce, death of a family member, birth or adoption or a change in my spouse's employment status. I also acknowledge that all dependents listed on this application are eligible for coverage under the all rules and guidelines stipulated for dependent coverage.

_____

Employee's Signature Date

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For Administrative Use Only

Employer Group Name_____ Effective Date of Coverage_____

Group Number_____ Subgroup Number_____

Class Number_____