LAST NAME		**DISTRICT**	Sheffield-Sheffield Lake
FIRST NAME		**SOCIAL SECURITY NUMBER**	

LAKE ERIE REGIONAL COUNCIL

1885 Lake Avenue, Elyria, Ohio 44035 440-324-5777 Fax: 440-324-4485

INSURANCE ENROLLMENT FORM-Please return to your district office

STREET ADDRESS		**CITY**		**ZIP CODE**	

BIRTH DATE		**SEX**		**DATE OF HIRE**		**EFFECTIVE DATE OF COVERAGE**	

STATUS	**SINGLE**		**MARRIED**		**MARRIAGE DATE**		**DIVORCED**		**WIDOWED**		**PHONE**

DEPARTMENT **Does not apply to Lorain, Vermilion**	**ADMINISTRATIVE**		**CERTIFIED**		**CLASSIFIED**		ADMIN-principal, superintendent, treasurer etc… CERTIFIED-teachers etc… CLASSIFIED-bus drivers, lunch room, etc…

MEDICAL PLANS	**SINGLE**	**FAMILY**	**DECLINE**	**ADDITIONAL MEDICAL PLANS** **Please note all schools do not offer these plans**	**SINGLE**	**FAMILY**	**DECLINE**
PREMIUM PLAN **ALL DISTRICTS** EXCEPT FIRELANDS				**STANDARD PLAN** ***CLEARVIEW, COLUMBIA, FIRELANDS KEYSTONE, LORAIN***			
MINIMUM VALUE PLAN **(High Deductible Plan)** **ALL DISTRICTS**				**BASIC PLAN** ***COLUMBIA, FIRELANDS, KEYSTONE, LORAIN***			
DENTAL PLANS	**SINGLE**	**FAMILY**	**DECLINE**	**VISION PLANS**	**SINGLE**	**FAMILY**	**DECLINE**
DELTA DENTAL PPO **All districts except those listed below**				**EYEMED** **All districts except those listed below** **AMHERST HAS NO VISION PLAN**			
DENTAL A PPO-AMHERST **DENTAL A 200-LORAIN**				**MMO STANDARD VISION** ***ESC AND KEYSTONE ONLY***			
DENTAL B EPO-AMHERST **DENTAL B-1000-LORAIN**							

I would like to cover the following dependents:

DEPENDENT	LAST NAME	FIRST NAME	DOB	SEX	SS#	MED	DEN	VIS
SPOUSE								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								

DOES SPOUSE WORK FOR A LERC SCHOOL DISTRICT?		**DISTRICT NAME**	

Are you or any dependent on Medicare?	**YES**		**NO**		**MEDICARE POLICYHOLDER**	

If you and/or your spouse are on Medicare but have coverage through LERC, your group health plan is primary and Medicare is secondary.

EMPLOYEE SIGNATURE		**DATE**	

By signing I agree that I received a HIPAA Notice of Special Enrollment Rights Statement

TREASURER/DESIGNEE SIGNATURE		**DATE**	

Please note that birth certificates, marriage certificates and Social Security Card copies may be requested when necessary.

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OTHER INSURANCE COVERAGE

Complete this form IF your spouse/dependents have OTHER coverage including other LERC Plans.

EMPLOYEE FIRST NAME		EMPLOYEE LAST NAME		SOCIAL SECURITY	

CLAIMS WILL NOT BE PAID IF YOU DO NOT CONFIRM OR DENY OTHER INSURANCE FOR YOUR DEPENDENTS

My dependents have no other coverage	YES		NO	

OTHER CARRIER INFORMATION	
INSURANCE CARRIER	
EMPLOYER	
NAME OF INSURED	
POLICY NUMBER	
EFFECTIVE DATE	
CANCELLED DATE	

LIST INDIVIDUALS COVERED UNDER THE OTHER PLAN AND SELECT PLAN COVERAGE (Medical/Dental/Vision/Prescription)

DEPENDENT	LAST NAME (if different)	FIRST NAME	MED/RX	DENTAL	VISION	INSURANCE PROVIDER NAME
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

EMPLOYEE SIGNATURE		DATE	

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HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within “30 days'' or any longer period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within “30 days'' or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.