Jefferson County Commission
Health Insurance Enrollment/Change Form
716 Richard Arrington, Jr., Blvd No. - Room A610
Birmingham, AL 35203
(205) 325-5249 – Phone (205) 325-5598 - Fax

INSTRUCTIONS

1. Please use pen, print clearly and press hard
2. Complete all the information requested.
3. Sign and date this form
4. Please forward completed form to Human Resources.
5. For name and /or address changes please contact the Payroll Department @ 325-5733

CHECK CHANGES DESIRED AND COMPLETE THE APPROPRIATE SECTION (S)

☐ ENROLLMENT ☐ CANCEL COVERAGE

COVERAGE TYPE

☐ SINGLE ☐ FAMILY

DEPENDENT CHANGE (List only those dependents to be added or removed.)

☐ Add Dependent ☐ Remove Dependent ☐ Student Extension

DATE EVENT OCCURED: (Example: Date of marriage, birthdate of child, etc.) _____

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	INITIAL	HOME PHONE	BUSINESS PHONE

ADDRESS	CITY	STATE	ZIP CODE	DATE OF BIRTH

CHANGE IN STATUS: A change in status **MUST** be requested within 30 days of the Qualifying Event. Jefferson County requires written documentation showing proof of all of the changes listed below. **Changes and new rates, if applicable, will be effective on the date of the Qualifying Event.**
LIST ALL DEPENDENTS ELIGIBLE UNDER THIS PLAN AND PROVIDE SOCIAL SECURITY NUMBER. THE SOCIAL SECURITY NUMBER FOR THE EMPLOYEE AND ALL DEPENDENTS MUST BE PROVIDED IN ORDER FOR THIS APPLICATION TO BE PROCESSED.

	Last Name	First Name	Social Security No. (*)	Date Of Birth	Male Or Female	Student Y/N	Other Health Coverage
01							
02							
03							
04							
05							

COORDINATION OF BENEFITS INFORMATION – If you, your spouse or your dependents are covered by any other group health insurance please give the following information

NAME OF CONTRACT HOLDER	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE OF COVERAGE	NAME OF INSURANCE COMPANY
EMPLOYER'S NAME	CITY	GROUP NUMBER	STREET ADDRESS
NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS	MEDICARE NUMBER		CITY, STATE, ZIP

I apply for the Group Health Benefits Certificate for which I am eligible. My application is subject to the terms and conditions of the agreement between my Employer and the Health Insurance Carrier. I understand that you may pay providers directly for services to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to process any of our claims. I will cooperate with you. If you need information about other health policies I have including payments by them, I will give them to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you. I acknowledge by my signature that I have read and understand the important information printed on the back of the application.

Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. I understand that misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees.

Effective Date of Change	**Jefferson County** Employer Name and Group No.	Employee Signature	Date

WHITE - Risk Management **YELLOW - Subscriber**