Benefits Enrollment Form

PLEASE FILL IN RESPONSES ONLINE. DO NOT PRINT. COMPLETE ALL SECTIONS WHEN APPLICABLE

MEDICAL MUTUAL Guardian

☐ New Enrollment ☐ Termination ☐ Change ☐ Other

Effective date

Reason for Change

Employer **CITY OF STOW**	Department **Name**

Member Information – All Fields Must be Completed

Employee First Name	Employee Last Name	Middle Initial	
Street Address	City	State	ZIP
Primary Phone	Email		

☐ Male ☐ Female	Hire/Rehire Date	Date of Birth	Social Security Number (SSN)[1]	Current Marital Status ☐single ☐widowed ☐married ☐divorced	[2]Date of marriage (if applicable)

[1] **Social Security numbers are required for all participants (employee and dependents) of the plan .**

copy of marriage license required

Benefit Options

Medical, RXx, Vision, & Dental Benefits (SELECT ONE): ☐ Single ☐ Family ☐ Waive Benefits

Dependents To Be Enrolled

Last Name, First Name, Mid Initial	Relationship[3]	Sex	Birth Date	Social Security Number (SSN)[1]	Other Insurance:
Spouse:		☐M ☐F			☐YES ☐NO
[3]**Child:**		☐M ☐F			☐YES ☐NO
[3]**Child:**		☐M ☐F			☐YES ☐NO
[3]**Child:**		☐M ☐F			☐YES ☐NO

*3*Proof of eligibility may be required.

Other Insurance (SELECT ONE) ☐ **No members of my family listed above are covered by any other plan of insurance.** ☐ **The following members are covered by other insurance plans as noted below.**

	Employee	Spouse	Child: _____	Child: _____
Policy Holder				
Insurance Company				
Coverage Tier	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY
Coverage Type	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION

Complete this section only if you wish to waive part of the coverage offered.

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Reason for Waiving medical, Rx, dental, vision coverage _____

Authorization

I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation, or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Medical Mutual. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature

Date