MUTUAL HEALTH SERVICES℠

Hancock County School Consortium
Coordinated Health/Care™

ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Change ☐Termination

Effective Date:_____

Reason for Change: _____

EMPLOYER:	SELECT ONE:	RETURN FORMS TO: SUPERINTENDENT'S OFFICE
McComb Local Schools	☐ Certified ☐ Classified ☐ Admin	328 S. TODD ST, MCCOMB, OH 45858

EMPLOYEE NAME: *Last, First, Middle:* *E-mail Address:*

ADDRESS: *Number & Street:* *Apt. #:*

City: *State:* *Zip:* *Phone:*

☐ Male ☐ Female	HIRE/REHIRE DATE:	DATE OF BIRTH:	SOCIAL SEC. #[1]:	CURRENT MARITAL STATUS ☐single ☐widowed ☐married ☐divorced	IF STATUS CHANGE: Date of change

[1]Social Security numbers are required for all participants (employee and dependents) of the plan. This number will not appear on your ID card. CMS Reporting requires the plan to report this information to Medicare administration.

PLEASE COMPLETE ALL APPLICABLE BENEFIT SELECTIONS

Medical/Rx	Dental	Vision
☐ Single ☐ Family	☐ Single ☐ Family	☐ Single ☐ Family

You will receive 2 cards at enrollment. If you need *additional* cards, check below:

☐2 ☐4 ☐6

DEPENDENTS TO BE ENROLLED

LAST NAME, FIRST NAME, MID INIT	RELATIONSHIP[3]	SEX	BIRTH DATE	SOCIAL SECURITY #[1]	BENEFITS
Spouse:		☐M ☐F			☐ M ☐ D ☐ V ☐ Rx
[2]Child:		☐M ☐F			☐ M ☐ D ☐ V ☐ Rx
[2]Child:		☐M ☐F			☐ M ☐ D ☐ V ☐ Rx
[2]Child:		☐M ☐F			☐ M ☐ D ☐ V ☐ Rx

[2]Proof of eligibility may be required. [3]Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify).

PRIMARY CARE PHYSICIAN

MEMBER NAME	PCP FIRST & LAST NAME	PHONE NUMBER (W/AREA CODE)	STREET ADDRESS CITY, STATE, ZIP	CURRENT PATIENT?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

OTHER INSURANCE

☐ No members of my family 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's Name:				
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

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 Mutual Health Services and/or Coordinated Health/Care. 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 of Employee _____ **Date Signed** _____

Signature of Employer _____ **Date Signed** _____

***** TO WAIVE ALL OR PART OF COVERAGE -- SEE REVERSE SIDE *****

COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED

Employee Name: _____ **Social Sec. Number** _____

Employer: McComb Local Schools

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.

Waiver of Coverage for: ☐ **Medical/Rx** ☐ **Dental** ☐ **Vision**

Reason for Waiving: _____

Signature of Employee _____ Date Signed _____

NOTICE OF PRIVACY PRACTICES

WE CARE ABOUT YOUR PRIVACY. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW CAREFULLY**.

I. USES AND DISCLOSURES OF HEALTH INFORMATION

The plan may use identifiable health information about you for obtaining coverage and benefits under the Plan; directing and coordinating your treatment for covered services under the Plan; obtaining payment for treatment on your behalf; Treatment, Payment and Operations ("TPO") of the Plan; Administrative purposes; Quality Assurance analysis including management of *Coordinated Health/Care* programs; and, evaluating the quality of care that you receive through the Plan.

The Plan may also use or disclose identifiable health information about you without your authorization for specific other reasons. The Plan provides information when otherwise required by law, such as for law enforcement in specific circumstances. Subject to certain requirements, we may give out identifiable health information without your authorization for public health purposes; abuse and neglect reporting; auditing purposes; research studies; funeral arrangements and organ donations; workers' compensation purposes; and emergencies. The Plan may provide information to the Plan Sponsor (the Employer) for purposes of (i) underwriting the Plan; (ii) modifying or terminating the Plan; and (iii) plan quality assurance, management and administration functions.

In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice in the manner employee communications are generally handled by the Employer. You may request a copy of our notice at any time. For more information about our privacy practices, contact the Human Resources office.

II. INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of identifiable health information about you that we use in administering the Plan. If you request copies, we will charge you 5 cents for each page. You also have the right to receive a list of instances where we have disclosed identifiable health information about you for reasons other than treatment, payment or healthcare operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your identifiable health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of this notice.

You may request in writing that we not use or disclose information for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. The Plan will consider your request, but is not legally required to accept it.

III. COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision we made about access to your records, you may contact the Human Resources office. You may also send a complaint to the U.S. Department of Health and Human Services. The Plan Administrator listed in the Plan Documents can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

IV. PLAN'S LEGAL DUTY

The Plan is required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice. If you have any questions or complaints, you should contact the Plan Administrator listed in the Summary Plan Document that fully describes the Plan.