Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)   www.opers.org

Health Care Coverage Application/Waiver of Coverage

This is an application for OPERS health care coverage for Traditional Pension Plan and Combined Plan benefit recipients. Please also consult the Health Care Guide *available on the web at www.opers.org or call 1-800-222-7377. The information provided on this application will be used in determining your eligibility for health care coverage. If you wish to waive medical/pharmacy coverage, complete Section 1 - Personal Information and Section 2 - Waiver of Medical/Pharmacy Coverage; otherwise complete Sections 1 and 3 through 9. If you waive medical/pharmacy coverage, you may still elect dental and/or vision coverage in Sections 6 and 7.*

Section 1 - Personal Information

Member Social Security Number

Beneficiary Social Security Number *(if applying for a survivor benefit)*

Applicant First Name   **MI**   **Last Name**

Street or Mailing Address   **Apt. Number**

City   **State**   **ZIP Code**   -

Home Phone Number   **Work Phone Number**   **Cell Phone Number**

Section 2 - Waiver of Medical/Pharmacy Coverage

Please read the following waiver carefully. Sign and date below before returning the form to OPERS only if you wish to waive coverage. By signing this form you are also waiving coverage for any of your dependents.

I hereby waive any coverage (excluding dental and vision plans) under hospital, medical, or prescription plans, including dependent coverage, as provided by OPERS under Section 145.58, Ohio Revised Code. This waiver shall be effective on the first day of the month following receipt of this form by OPERS and shall remain in effect unless revoked as described below.

I understand and acknowledge that coverage, payment for any expenses or claims incurred, and reimbursement payable for me or my dependents shall be forever forfeited from the effective date of this waiver until the waiver is revoked. I may revoke the waiver by filing a health care enrollment application:

- During the annual open enrollment period for health care coverage under the retirement system. The waiver remains in effect until January 1 of the next year.
- Within 31 days of involuntary termination of coverage under another group plan. Evidence of my involuntary termination of coverage must be provided to OPERS at the time of my filing a health care enrollment application. The waiver remains in effect until the first of the month if the application is received by the 15th day of the preceding month; otherwise, the waiver remains in effect until the first of the next succeeding month.

Recipient's Signature ____________________   Today's Date ____________

Do not print or type name

Section 3 - Dependent Coverage for Spouse

Complete this Section if you wish to enroll your eligible spouse in the medical/pharmacy, vision, or dental plan(s). In order to ensure that OPERS is providing coverage only to eligible spouses, OPERS must confirm that your spouse meets the definition of an "eligible dependent" pursuant to Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. Please review the eligibility information stated in the OPERS Health Care Guide *to determine if your spouse is an eligible dependent. OPERS also requires that copies of your marriage certificate and your spouse's birth certificate must accompany this Form before eligibility for coverage can be verified. You must certify your spouse's eligibility for coverage in Section 9 of this Form and must notify OPERS within 30 days of any change in your spouse's eligibility. You are responsible for any claim overpayments resulting from your failure to notify OPERS that your spouse has become ineligible for health care coverage.*

Spouse First Name   **MI**   **Last Name**

Date of Birth   **Male**   **Female**   **Social Security Number**

Gender

Section 4 - Dependent Coverage for Children

Complete this Section if you wish to enroll your eligible children in the medical/pharmacy, vision, or dental plan(s). In order to ensure that OPERS is providing coverage only to eligible children, OPERS must confirm that the individuals you enroll meet the definition of an "eligible dependent" pursuant to Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. Please review the eligibility information stated in the OPERS Health Care Guide *to determine if your child(ren) is/are an eligible dependent(s). OPERS also requires that a copy of each eligible child's birth certificate or decree of adoption accompany this Form before eligibility for coverage can be verified. Please attach another sheet for any additional children and provide all the information requested below for each child. You must certify each child's eligibility for coverage in Section 9 of this Form and must notify OPERS within 30 days of any change in each child's eligibility. You are responsible for any claim overpayments resulting from your failure to notify OPERS that your child(ren) has/have become ineligible for health care coverage.*

1. Child First Name **MI** **Last Name**

Date of Birth **Male** **Female** **Social Security Number**

Gender

Relationship to member:

Biological or legally adopted child

Grandchild for whom the member has been ordered to provide health care coverage under Section 3109.19, Ohio Revised Code *(Please provide a copy of the court order.)*

A. Is this child under the age of 18 and never been married? **Yes** **No** *(If yes, please skip questions B, C, and D.)*

B. Is this child under age 22, never married, and attending an accredited school on a full-time basis at least five months of the year? **Yes** **No** *(If No, please go to questions C, D, and E. If Yes, please provide the following school information.)*

Name of university, college, institution

Month **Day** **Year**

Anticipated graduation date

C. Regardless of current age, did this child become incapacitated prior to age 18 and never married? **Yes** **No**

D. Regardless of current age, did this child become incapacitated after age 18 but prior to age 22, and never married, while attending an accredited school on a full-time basis at least five months of the year? **Yes** **No**

E. Do you or can you claim this child on your federal income tax return? **Yes** **No**

*If no, please explain*____

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2. Child First Name **MI** **Last Name**

Date of Birth **Male** **Female** **Social Security Number**

Gender

Relationship to member:

Biological or legally adopted child

Grandchild for whom the member has been ordered to provide health care coverage under Section 3109.19, Ohio Revised Code *(Please provide a copy of the court order.)*

A. Is this child under the age of 18 and never been married? **Yes** **No** *(If yes, please skip questions B, C, and D.)*

B. Is this child under age 22, never married, and attending an accredited school on a full-time basis at least five months of the year? **Yes** **No** *(If No, please go to questions C, D, and E. If Yes, please provide the following school information.)*

Name of university, college, institution

Anticipated graduation date

C. Regardless of current age, did this child become incapacitated prior to age 18 and never married? **Yes** **No**

D. Regardless of current age, did this child become incapacitated after age 18 but prior to age 22, and never married, while attending an accredited school on a full-time basis at least five months of the year? **Yes** **No**

E. Do you or can you claim this child on your federal income tax return? **Yes** **No**

*If no, please explain*____

 See next page

Section 5 - Medical/Pharmacy Coverage Selection

Choose your coverage and indicate the person(s) you wish to enroll. If you are enrolling in the OPERS plan (Aetna or Medical Mutual) and you or your spouse are not eligible for Medicare, you must contact Aetna or Medical Mutual for information on participating providers. If you and your spouse (if enrolled) are eligible for Medicare, live in the U.S. and choose the Aetna Enhanced Plan, we will enroll you in the Aetna Medicare Open Plan. This plan is not available to retirees whose covered spouses are not eligible for Medicare or who are covering dependent children. For more information, refer to the Health Care Guide *available on the web at www.opers.org or call 1-800-222-7377.*

I elect the following Medical/Pharmacy coverage administrator *(choose only one)***:**

Aetna *(1-800-645-5677)*

Medical Mutual *(1-800-854-8139)*

Kaiser **AultCare**

(You must contact Kaiser or AultCare directly for an enrollment application which must be completed and returned to OPERS along with this Form)

I elect the following Aetna or Medical Mutual option *(choose only one)***:**

Enhanced Plan **Intermediate Plan** **Basic Plan**

I elect this Medical/Pharmacy coverage option for *(choose all that apply)***:**

Myself **Spouse** **1 Child** **2+ Children**

Name(s) of child(ren) being enrolled____

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Section 6 - Vision Coverage Selection

If you receive a monthly OPERS benefit, you may apply for the vision plan even if you are not eligible for or waive OPERS medical/pharmacy coverage. Indicate your choice of coverage (high or low) and who you wish to enroll in this plan. If you choose to decline vision coverage, your next opportunity to elect coverage will be during open enrollment. OPERS health care open enrollment takes place each October with coverage effective January 1 of the following year.

I decline VISION coverage at this time.

I elect VISION coverage in the *(choose only one)***:**

High Option **Low Option**

I elect this VISION coverage for *(choose all that apply)***:**

Myself **Spouse** **1 Child** **2+ Children**

Name(s) of child(ren) being enrolled____

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Section 7 - Dental Coverage Selection

If you receive a monthly OPERS benefit, you may apply for the dental plan even if you are not eligible for or waive OPERS medical/pharmacy coverage. Indicate your choice of coverage (high or low) and who you wish to enroll in this plan. If you choose to decline dental coverage, your next opportunity to elect coverage will be during open enrollment. OPERS health care open enrollment takes place each October with coverage effective January 1 of the following year.

I decline DENTAL coverage at this time.

I elect DENTAL coverage in the *(choose only one)***:**

High Option **Low Option**

I elect this DENTAL coverage for *(choose all that apply)***:**

Myself **Spouse** **1 Child** **2+ Children**

Name(s) of child(ren) being enrolled____

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See next page

Section 8 - Medicare and Other Coverage

OPERS requires that you enroll in the Medicare program when you are first eligible for Medicare coverage. For more information on how Medicare and other insurance affects your OPERS coverage, refer to the Health Care Guide.

A. Do you receive another benefit from OPERS or any other Ohio retirement system(s)? *(Please mark all that apply)*

OPERS **STRS** **SERS** **OP & F** **HPRS** If so, please provide the account number

B. Are you eligible for Medicare? **Yes** **No**

If "Yes," provide a copy of your Medicare card or a statement issued by Social Security confirming your Medicare effective date.
If "No," proceed to Question E below.

C. If you are enrolled in Medicare B, do you want your medical claim information forwarded from Medicare to your OPERS health care administrator? **Yes** **No**

D. You are entitled to the Medicare B reimbursement from OPERS as long as you are enrolled in Medicare B coverage and do not receive reimbursement of the Medicare B premium, or your Medicare B premium is not paid on your behalf by another source. You must notify OPERS immediately if you become ineligible for the Medicare B reimbursement. You are responsible for any overpayment of the Medicare B premium.

Do you receive reimbursement or payment of your Medicare B premium from another source? **Yes** **No**

If "Yes," indicate whom the reimbursement or payment is from ____________________

E. Does your spouse receive a benefit from OPERS or any other Ohio retirement system(s)? *(Please mark all that apply)*

OPERS **STRS** **SERS** **OP & F** **HPRS** If so, please provide the account number

F. Is your spouse eligible for Medicare? **Yes** **No**

If "Yes," provide a copy of his/her Medicare card or a statement issued by Social Security confirming the Medicare effective date.
If "No," proceed to Section 9 below.

G. If your spouse is enrolled in Medicare B, does your spouse want medical claim information forwarded from Medicare to your OPERS health care administrator? **Yes** **No**

Section 9 - Acknowledgment

Please read the following acknowledgment carefully. Sign and date below before returning the form to OPERS.

By enrolling in OPERS health care coverage, I acknowledge that OPERS and my chosen health care vendor may have contact with each other, including the sharing of my personal health information, for purposes of administering my coverage.

I acknowledge that the information provided on this Form is true and the enrolled dependents are eligible for coverage, as defined by Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. I acknowledge that it is my responsibility to notify OPERS within 30 days of a dependent becoming ineligible for coverage and that I will be responsible for all overpaid claims resulting from my failure to notify OPERS. I authorize the appropriate premium (if applicable) for the coverage I am requesting, including dependent coverage (if applicable), to be deducted from my OPERS benefit check.

I acknowledge that, while OPERS provides health care coverage options for its benefit recipients and their eligible dependents, health care coverage is not a statutorily-mandated benefit, but it will be provided to OPERS benefit recipients to the extent OPERS' resources permit.

Recipient's Signature ______________________________ **Today's Date** ____________

Do not print or type name