CHEMUNG COUNTY HEALTH INSURANCE ENROLLMENT ELECTION

Employee Information:

Name:_____ County Department:_____

Address:_____ Title:_____ Union:_____

_____ Employment Status:

Social Security Number:_____ ☐ Active Fulltime _____ hours per week

Date of Birth:_____ ☐ Active Part-time _____ hours per week

You are eligible for Health Benefits under the Chemung County Program effective _____.
(If blank, effective date information will be provided at new employee orientation or upon the enrollment offer.)

Please make an election below: It is mandatory that you make an election, however, failure to make an election will result in a declination to enroll. Please be advised that you are responsible for making sure you have insurance coverage.

☐ I wish to enroll under the Chemung County Health Benefits Program available to me. I acknowledge that Chemung County offers full time employees a coverage option that meets minimum value and affordable coverage standards. I have been provided with the Summary of Benefits and Coverage (SBC). I understand that I will be required to legibly complete and sign enrollment forms and provide any required documentation to enroll in a timely manner. If required information is not provided, it will delay my enrollment.

_____

Employee Signature *Date*

OR

☐ I acknowledge that Chemung County offers full time employees a coverage option that meets minimum value and affordable coverage standards. I have been provided with the Summary of Benefits and Coverage (SBC). I hereby decline enrollment under any option of the Chemung County Health Benefits Program that is available to me. I release and discharge the County from any and all actions, claims, and expenses, including medical expenses, known or unknown, and any other benefits provided to employees and dependents covered by Chemung County Benefits Program. I certify that all information on this form is accurate and complete. I understand that by declining coverage, I will not be eligible to re-enroll until January 1 of the next plan year, unless I qualify for a special enrollment under HIPAA Legislation.

Do you or your dependents have any other health insurance coverage? ☐ Yes ☐ No

Insured Name:_____ Employer:_____

Relationship to Employee:_____ Date of Birth:_____

YOU MUST ATTACH PROOF OF OTHER QUALIFYING COVERAGE AND LIST INFORMATION BELOW.

	Insurance Carrier	Coverage Effective Date	Plan Covers All Family Members?
Medical/Hospital	_____	_____	☐ Yes ☐ No*
Prescription	_____	_____	☐ Yes ☐ No*
Vision	_____	_____	☐ Yes ☐ No*
Dental	_____	_____	☐ Yes ☐ No*

** If not all family members covered by other insurance, please define:*_____

If you are eligible and interested in the health insurance buyout, you also will need to complete the declination form.

_____

Employee Signature *Date*

Revised 10/1/14

ABCD. FGJ

CHEMUNG COUNTY
POLICY & MANDATORY NOTICE ACKNOWLEDGMENT
ALL EMPLOYEES ELIGIBLE FOR HEALTH INSURANCE

I have been furnished with a copy of the following Chemung County Policies & Mandatory Notices:

- **Summary of Benefits and Coverage (SBC)**
  The SBCs were prepared by Excellus as required by the Affordable Care Act.

- **Glossary of Health Insurance and Medical Terms**
  The Glossary was created by Excellus to assist with many commonly used terms and definitions.

- **HIPAA – Chemung County Notice of Health Information Practices**
  By Signing, I acknowledge receipt of this notice.

- **Chemung County Subscriber Responsibility**
  By signing I acknowledge receipt, and have reviewed the Subscriber Responsibility rules. I also acknowledge that my subscriber responsibilities may change from time to time, and that I have an obligation to follow through with these responsibilities. I hereby certify that all information provided is accurate and complete. I understand my responsibilities to notify the Chemung County Insurance Department with any changes to my eligibility information. If at any time any of my dependents or I become ineligible for health insurance under this plan, it is understood that failure to report this information within 30 days can result in having to reimburse the County for any costs incurred including premiums for coverage or claims paid.

_____ _____

Signature of Employee Date

_____

Print Name

PLEASE KEEP THE POLICIES AND NOTICES FOR YOUR RECORDS.

RETURN ACKNOWLEDGMENT FORM TO:
Chemung County Insurance Department
PO Box 588
Elmira, NY 14902-0588

1/8/18

All Plans

Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association
P.O. Box 21146, Eagan, MN 55121

DO NOT USE – FOR INTERNAL PURPOSES ONLY
HIOS ID#_____
EC_____

Instructions on last page. All Dates = mm/dd/yy

GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY

1 – Group Employer Information

This section should be completed by the Group Benefits Administrator.
This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

Group # 00033682 Subgroup # Class#

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature/Date

X

Dental Group # 00113352 Subgroup #

Subscriber Status: ☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:
☐ Left Employ/Retirement ☐ Death of Spouse
☐ Divorce/Legal Separation ☐ Dependent Reached Max Age
☐ Loss of Student Status ☐ Other _____

Effective Date

COBRA Effective Date

Hire/Rehire Date

Retired Effective Date

Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ No ☐ Yes

If yes, what was the start date: and end date

EMPLOYER

2 – Subscriber Plan Selection

Department # Employee #

Please use blue or black ink, print one character per box. Check applicable plan(s).

Please check coverage type and person(s) to be covered:

☐ Medical ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family
☐ Dental ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family

CHEMUNG COUNTY

☐ Classic Blue/Indemnity - C
☐ Blue PPO - A
☐ Blue PPO2 - B
☐ Blue PPO 3 - J
☐ Dental - D (7/1/2020)

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐
☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Age 65+ ☐ Remove Dependent ☐ Change in Student Status
☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Newborn ☐ Disability ☐ End Stage Renal Disease
☐ Add Dependent / Please indicate reason for adding dependent: ☐ Adoption ☐ Marriage ☐ Marital Status Change

4 – Subscriber Information

Please complete both sides of this application.
The subscriber signature is required in order to process the application.

SUBSCRIBER

Subscriber's Last Name Subscriber's First Name

Middle Initial Title E-mail Address

Mailing Address Apt or Suite

City State Zip

A, B, C, J + D

SUBSCRIBER

Work Phone Number ☐☐☐-☐☐☐-☐☐☐☐ Home Phone Number ☐☐☐-☐☐☐-☐☐☐☐ Cell Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐ Gender ☐ M ☐ F Social Security Number* ☐☐☐-☐☐-☐☐☐☐

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced/ Marital Status Event Date ☐☐/☐☐/☐☐☐☐

Medicare Number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐ Part A Effective Date ☐☐/☐☐/☐☐☐☐ Part B Effective Date ☐☐/☐☐/☐☐☐☐

If Medicare eligible due to ESRD please check type of dialysis: ☐ Self administered ☐ Facilitated Date started ☐☐/☐☐/☐☐☐☐

5 – Other Coverage Information Have you ever been a member of Excellus BlueCross BlueShield? ☐ Yes ☐ No

~~**In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.**~~

Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? ☐ No ☐ Yes /Dental? ☐ No ☐ Yes

If answering "Yes", are you keeping the additional health or dental coverage? Health? ☐ No ☐ Yes / Dental? ☐ No ☐ Yes

Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: Effective Date ☐☐/☐☐/☐☐☐☐ Termination Date ☐☐/☐☐/☐☐☐☐

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ☐ Medical /Reason_____ Date ☐☐/☐☐/☐☐☐☐

☐ Dental /Reason_____ Date ☐☐/☐☐/☐☐☐☐

Dependent (list each dependent in section 7)

☐ Medical / Reason _____ Date ☐☐/☐☐/☐☐☐☐

☐ Dental / Reason_____ Date ☐☐/☐☐/☐☐☐☐

7 – Dependent Information

Please provide all information for each person to be covered.

SPOUSE

Subscriber's Last Name Subscriber's First Name

Spouse Last Name Spouse/Domestic Partner First Name M.I.

☐ Male ☐ Female Date of Birth ☐☐/☐☐/☐☐☐☐ Social Security Number* ☐☐☐-☐☐-☐☐☐☐ Are you enrolling as a Domestic Partner? ☐ Yes ☐ No

Medicare Number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐ Part A Effective Date ☐☐/☐☐/☐☐☐☐ Part B Effective Date ☐☐/☐☐/☐☐☐☐

DEPENDENT

Dependent's Last Name Dependent's First Name M.I.

☐ Male ☐ Female Date of Birth ☐☐/☐☐/☐☐☐☐ Social Security Number* ☐☐☐-☐☐-☐☐☐☐ Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name Expected Graduation Date ☐☐/☐☐/☐☐☐☐ Credit hours ☐☐

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature **Date**

Excellus
A nonprofit independent licensee of the BlueCross BlueShield Association
P.O. Box 21146, Eagan, MN 55121

GROUP ENROLLMENT FORM

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 – Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name | Subscriber's First Name

DEPENDENTS

Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number* ___-___-___ | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

---

Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number* ___-___-___ | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

---

Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number* ___-___-___ | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

---

Dependent's Last Name | Dependent's First Name | M.I.

☐ Male ☐ Female | Date of Birth | Social Security Number* ___-___-___ | Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No (See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible
Commercial
COBRA Begin Date
COBRA Handicapped/Disabled Date
Transfer to Traditional
Transfer to HMO
Transfer to POS
COBRA End Date
Subscriber Request
Subscriber Deceased
Spouse's Insurance
Medicaid
Medicare

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law
Dependent Over Age
Deceased
Ineligible Student
COBRA Begin Date
Subscriber Request
Divorce
Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than seven dependents please use an additional form.
*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

QUALIFIED GUIDELINES:

- A legal spouse (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group:
  - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

  Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**

  I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- (Applies to Dental Only) The certificate or contract for which application is being made may impose a waiting period on member(s) up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative
Or, visit us at:
www.excellusbcbs.com

CHEMUNG COUNTY HEALTH INSURANCE DEPARTMENT
OTHER INSURANCE COVERAGE INFORMATION FORM
Required Form - Please Print Legibly

Subscriber Information:

Name:_____ SSN:_____ DOB:_____

Address:_____ Home Phone:_____ ☐ Male ☐ Female

_____ Department:_____ Union:_____

Eligible Dependent Information:

NAME	RELATIONSHIP	SSN	DOB	
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female

Do you, your spouse/dependents have any other health insurance coverage? ☐ **Yes** ☐ **No**
(as of effective date)

Besides Chemung County

If yes, complete each applicable coverage section and sign the form below.
If coordination of benefits for dependents should not be calculated by the birthday rule, please indicate which coverage is primary and reason (ie. court order):_____

If no, but you, your spouse or dependents previously had other coverage, please complete each applicable coverage section, indicate the date other coverage listed ended, complete each section and sign the form below.
Please note: You may need to provide proof of coverage end date. (other coverage in last 63 days)

Other Insurance Information:

Insured Name:_____ Employer:_____

DOB:_____ Relationship to covered family members:_____

COVERAGE TYPE	INSURANCE CARRIER	SUBSCRIBER ID#	EFFECTIVE DATE	ALL FAMILY MEMBERS COVERED?	COVERAGE END DATE
MEDICAL	_____	_____	_____	☐ Yes ☐ No*	_____
PRESCRIPTION	_____	_____	_____	☐ Yes ☐ No*	_____
VISION	_____	_____	_____	☐ Yes ☐ No*	_____
DENTAL	_____	_____	_____	☐ Yes ☐ No*	_____

**If not all family members covered by other insurance, please define who is covered under which plan(s):*

_____

_____

_____

I hereby certify that all information provided on this form is accurate and complete. I understand that it is my responsibility to notify the Chemung County Insurance Department with any changes to the information on this and all enrollment forms. If at any time any of my dependents or I become ineligible for health insurance under this plan, it is understood that failure to report this information within 30 days can result in having to reimburse the County for any costs incurred including premiums for coverage or claims paid.

_____

Subscriber's Signature *Date*

Revised 10/11/19

All Plans

Guardian

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Group Insurance Enrollment Form

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer

Employer Name: **COUNTY OF CHEMUNG** | Group Plan Number: **00028366** | Benefits Effective: _____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change

Class: CHEMUNG COUNTY Division: N/A Subtotal Code: Class# (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Employer Provided Identification: N/A

Social Security Number: ___-___-____

Please print clearly on form.

Address | City | State | Zip

Gender: ☐ M ☐ F Date of Birth (mm-dd-yy): ___-___-___

Phone (indicate primary): ☐ Home (___) ___-____
☐ Work (___) ___-____
☐ Mobile (___) ___-____

Email Address (indicate primary) ☐ Home _____ ☐ Work _____

Are you married ☐ Yes ☐ No Date of marriage/union: ___-___-____
Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child: ___-___-____

About Your Job:

Job Title:

Work Status:
☐ Active ☐ Retired ☐ Cobra/State Continuation
Hours worked per week: _____

Date of full time hire: ___-___-___

About Your Family:

Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number must be provided if enrolling. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Spouse Address/City/State/Zip: Phone: ( ) -		Gender ☐ M ☐ F	Social Security Number ___-___-____ Date of Birth (mm-dd-yyyy) ___-___-____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number ___-___-____ Date of Birth (mm-dd-yyyy) ___-___-____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Only list addresses/phone numbers for dependents, if different than yours.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Nov 15, 2021

Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Vision Coverage:

You must be enrolled to cover your dependents. Check only one box.

Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
❑	❑	❑	❑

❑ I am covered under another Vision plan
❑ My spouse is covered under another Vision plan
❑ My dependents are covered under another Vision plan

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I agree that my [employer] or my employer's designated administrator may deduct premiums from my pay withdraw premiums from my designated bank account, if they are required for the coverage I have chosen.
- By my signature below, I affirmatively consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice
- By my signature below, I affirmatively consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I state that the information provided above is true and correct to the best of my knowledge and belief.**

Guardian Group Plan Number: **00028366** Please print employee name:

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Enrollment Kit 00028366, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

*Vision Plan For CSEA + Sewer District Union employees

CSEA Employee Benefit Fund Enrollment Form

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CSEA EMPLOYEE BENEFIT FUND
PO Box 516
Latham, NY 12110
800-323-2732
www.cseaebf.com

Employee Information (Please Print)

Social Security # _____ Date of Birth ____/____/____

Name (First, Middle Initial, Last) _____ Please (✓) one: ☐ M ☐ F

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employee's Daytime Phone # _____ Email _____

Name of Employer CHEMUNG COUNTY OR405 OZ411 EFFECTIVE DATE: _____

Spouse Information

Please (✓) one: ☐ Spouse Date of Marriage ____/____/____ Please (✓) one: ☐ M ☐ F

Name (First, Middle Initial, Last) _____

Date of Birth ____/____/____ Social Security # _____

Dependent Children Information (For relationship, please indicate: Son, Daughter, Step-child or other)

Last Name _____ First Name _____ Date of Birth ____/____/____ ☐ M ☐ F Relationship _____

Last Name _____ First Name _____ Date of Birth ____/____/____ ☐ M ☐ F Relationship _____

Last Name _____ First Name _____ Date of Birth ____/____/____ ☐ M ☐ F Relationship _____

Last Name _____ First Name _____ Date of Birth ____/____/____ ☐ M ☐ F Relationship _____

*Important Information concerning dependent coverage

- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
- An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct:

Member's Signature _____ Date _____

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