OAKLAND COUNTY RETIREES MEMBERSHIP & RECORD CHANGE FORM

PERSONAL INFORMATION			COBRA____ HPS____ CPS___
Retiree Last Name	**First Name**	**M.I.**	
Home Address ☐ New	**City**	**State**	**Zip Code**
Telephone	**Ret/Emp ID.**		

HEALTH PLAN OPTIONS

☐ BCBS PPO 1/Optum Rx	☐ BCN/BCN Rx	☐ Waive Medical/Rx
☐ BCBS PPO 2/Optum Rx	☐ Medicare Supplemental Plan/Optum Rx	☐ Waive Dental Standard
☐ BCBS Traditional/Optum RX	☐ NVA Vision Standard	☐ Waive Vision Standard
	☐ Delta Dental Standard	☐ Waive Supplemental/Rx/Reimb

ADD Members to Plan

EVENT	Name (First & Last)	Event Date	Date of Birth	Social Security	Sex
☐ Marriage*					
☐ Birth*					
☐ Stepchild*					
☐ Child legal Adoption*					
☐ Child legal Guardian*					
☐ Sponsored Dependent					
☐ Other					

REMOVE Members from Plan

Event	Name (First & Last)	Event Date	Date of Birth
☐ Divorce*			
☐ Death			
☐ Loss of Dependency*			
☐ Other			

***COBRA Supplemental Information**

Under Federal law Oakland County is required to offer the opportunity to continue health coverage to members on your health plan who lose coverage for various reasons. Please complete this section with regard to the person(s) you are removing from your health plan so we may direct the required correspondence correctly.

☐ Divorce	Former spouses Address:	City	State, Zip Code
☐ Remove a Child	Child(ren)s Address:	City	State, Zip Code

Other Changes

☐ Name Change:	From:	To:	Effective:	Reason:
☐ Additional information:				

CONTINUE →

I certify the information provided on this form is true and correct to my knowledge and belief and understand improperly enrolling or continuing coverage for an ineligible member may result in recovery of improperly paid claims. **Retiree Signature** _____	**Date**

This Section for Office Use Only

COMMENTS:

Effective	Group Sig.	Group/Div

Guidelines for Adding Members To Your Contract

MARRIAGE	You may complete & submit this form up to **30 days** after the date of the marriage. You must submit a copy of your marriage license and spouse Social Security Card with this form. Coverage becomes effect the date of the marriage.
BIRTH OF CHILD	Report a birth within 30 days of the birth date. A copy of the birth certificate and Social Security Card is required with this form.
STEP CHILD	You may complete this form up to 30 days before or 30 days after the marriage. A copy of the birth certificate(s), child's Social Security Card and marriage license is required with this form.
CHILD BY LEGAL ADOPTION	Report within 30 days of the date of petition or date child takes up residence, whichever is later. A copy of the legal documentation and child's Social Security Card is required with this form.
CHILD BY LEGAL GUARDIANSHIP	Report within 30 days of the date of petition or date child takes up residence, whichever is later. A copy of the legal documentation and child's Social Security Card is required with this form.
OTHER	Use this area to request the addition of any other eligible dependent not listed above.

Guidelines for Removing Members To Your Contract

DIVORCE	Include the name of the divorced spouse and date of divorce judgment. Indicate if coverage for the child(ren) is to be continued on the subscriber's contract. Complete the "COBRA Supplement Information" section. Be sure to include the social security number and address of the divorced spouse in this section.
DEATH OF DEPENDENT	Give the name of the deceased dependent, date of death and a copy of the death certificate.
DEPENDENT MISC.	Use this form to remove dependents who are no longer meet eligibility requirements such as age, obtain other coverage, etc. and complete the "COBRA Supplement Information" section.
OTHER	Use this area to request the deletion of any other (or additional) dependent not covered above and complete the "COBRA Supplement Information" section.
ADDITIONAL INFORMATION	This section may be used for misc. information and to provide names, address, social security numbers and other information specifically requested in other areas of this form.

Coordination Of Benefits (COB) and Other Coverage Information

Is any member(s) enrolling in the County Retiree plan covered by any other health coverage? Yes ☐ NO ☐	If yes, coverage provided by his/her employer Yes ☐ NO ☐
Carriers Name:	Primary Cardholders Name:
Policy Number:	Type: Medical ☐ Dental ☐ Vision ☐
Is any member enrolling in a County Retiree plan covered under COBRA? Yes ☐ NO ☐	If yes, list COBRA effective date and attach a copy of the COBRA election form: Members name: _____
Is any member enrolling covered by Medicare Part A ☐ Part B ☐ Part D (Rx) ☐ ?	If yes, do they have Medicare Supplement? Yes ☐ NO ☐ Carriers Name:

Is there a Court order for any child listed above that states which parent is responsible for providing health insurance? Yes ☐ No ☐
If yes, attach a copy of the Court order and indicate the following:

1. Who is responsible for providing health care for the child(ren) listed above? Mother ☐ Father ☐ Both ☐
2. Who has physical custody of the child(ren) listed above? Mother ☐ Father ☐ Both ☐

Authorization For Release Of Protected Health Information

By signing below as a Retiree or dependent, I authorize the use or disclosure of my individually identifiable health information by or to any family members, any health care provider, the plan sponsor, the insurer/TPA of the plan or any other entity providing services in connection with the plan in order to process my enrollment in the plan or to process any claim for my plan benefits. This authorization is effective until the date I terminate enrollment in the plan. Further, I have read and understand the following: 1) I may revoke this authorization at any time before its expiration date by notifying the plan in writing, but the revocation will not have any effect on any actions the plan took before it received the revocation; 2) I may see and copy the information described on this authorization if I ask for it;
3) I am not required to sign this authorization to receive my health care benefits (enrollment, treatment or payment) and 4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Retiree Signature:	Date:
Spouse Signature:	Date:
Dependent Signature**:	Date:
Dependent Signature**:	Date:

**Children age 18 or older should sign on the "Dependent Signature" line. Minor children are not required to sign this form.