OBERLIN COLLEGE

Active Employee Benefits Enrollment Form

EMPLOYEE INFORMATION – Please Print Clearly

Last Name		First Name	MI	Faculty ☐	Administrative Assistant ☐
				A&PS ☐	Security ☐
T number (include all 0's)		Address and Phone		Confidential ☐	Service ☐

COVERAGE ELECTION INFORMATION

Last Name (if different from above)	First Name	Health – Traditional PPO (Plan A/B)	Health – CDHP with HSA	Vision	Superior Dental Core Plan	Superior Dental Enhanced Plan	Superior Dental Network Only	Social Security Number	Gender	Date of Birth	I decline health coverage. (provide reason)
Self (employee)	-------	☐	☐	☐	☐	☐	☐	--- -- ----	----	----------	
Spouse/DP*		☐	☐	☐	☐	☐	☐				
Child		☐	☐	☐	☐	☐	☐				
Child		☐	☐	☐	☐	☐	☐				
Child		☐	☐	☐	☐	☐	☐				
*spouse or domestic partner as used by Oberlin College.		☐	☐	☐	☐	☐	☐				

OTHER INSURANCE – see reverse side for College Policy

Spouse/DP*/Adult Child must take individual health coverage from their employer if eligible.
Is your Spouse/DP*/Adult Child employed? ◯ Yes ◯ No

Spouse/DP*Adult Child's employer _____
Is your Spouse/DP*/child eligible for health care from their employer?
◯ Yes ◯ No
Is another person legally responsible for your children's health care? ◯ Yes ◯ No

If you answered Yes to any of the above questions, please complete the following:
Spouse/DP's* Insurance Co. Name _____
Type of Coverage: ◉ Single Coverage ◯ Family Coverage

Child's Insurance Co. Name _____
Is your Spouse/DP* covered by Medicare? ◯ Yes ◯ No

Part A Effective Date_____Part B Effective Date_____

AUTHORIZATION

The terms of the Health Plan have been explained to me, and I have complete understanding of my rights and responsibilities under the Plan. I hereby authorize my employer to make payroll deductions for the premium required for participation in the Plan. I hereby authorize my licensed physician, practitioner, hospital, clinic, medical-related facility, insurance company, employer, or other organization that has any records or knowledge of personal information, medical history, physical condition, or treatment of me or my dependent(s) to release this information to our third party administrator or their authorized representatives.

I understand that any willful misrepresentation of facts on this enrollment form will be grounds for discharge and termination of benefits as well as Insurance Fraud. I hereby certify that the foregoing information is true and correct to the best of my knowledge.

Employee Signature_____Date _____

Date of Hire	Effective Date	Cancel Date

Coordination of Benefits:

- If both you and your Spouse/Same Gender Domestic Partner* are employed by Oberlin College and want health coverage, both employees must carry single health coverage.
- If you have other dependents and want family coverage, the employee with the higher salary must carry the health coverage.
- The spouse (if employed) of an Oberlin College employee must take at least single coverage from their employer. (see below)

Clarification – Spousal coordination of benefits:

- A spouse who is employed by employers other than Oberlin College MUST enroll in the health insurance program made available through their employer if an employer-sponsored group health plan is available when certain conditions are met.

- A spouse is required to participate in their employer-sponsored health care plan if: 1) they has access to continuous (i.e., non-seasonal) group health coverage through his/her employment, and 2) the employer contributes at least 50% of the premium.

- If these conditions are met, your spouse must enroll in the employer's health care plan regardless of the cost of coverage or the level of benefits provided. If your spouse is eligible for coverage through their employer and does not take that coverage, he/she is not eligible for coverage under the College plan.

- If your spouse is self-employed and does not have access to group health coverage, or if your spouse is not working or is not eligible for coverage through their employer, then he/she is eligible to participate in Oberlin College's health plan. If your spouse must wait until an open enrollment period to enroll for coverage under his/her employer's plan, he/she is required to enroll in the employer's plan during its next open enrollment period. In the meantime, your spouse will be eligible to participate in the College's plan.

- You will need to indicate whether your spouse is eligible for other employer-sponsored healthcare coverage. You will be asked to certify that your spouse has coverage and to provide information about that coverage or to certify that his or her employer does not offer medical coverage. If you do not respond or are untruthful, your health insurance may be terminated.

- By enrolling in the Oberlin College Health Plan you agree to have your premiums taken from your check before income taxes are calculated.

CDHP:

- If you elect the CDHP plan and you intend to contribute your own funds, you must complete an HSA Contribution Election Form.

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The Department of Human Resources is required to ensure that only employees, retirees, and their eligible dependents are receiving health care under the Oberlin Health Plans. As a result, the Department of Human Resources must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, domestic partners, and children) must submit the following documentation in addition to the appropriate health benefits enrollment form. If documentation is already on file with The Department of Human Resources, you will not be required to re-submit.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE / SAME GENDER SPOUSE	A person of the opposite and/or same gender to whom you are legally married.	A photocopy of your Marriage Certificate, Social Security Card **and** a photocopy of the top half of the front page of your most recently filed federal tax return** (Form 1040) that includes the spouse
SAME GENDER DOMESTIC PARTNER	A person of the same gender with whom you have entered into a domestic partnership.	A signed Domestic Partnership Affidavit, a copythe partner's Social Security Card, and a photocopy of **two** of the following: • Bank statement indicating joint ownership of bank account • Ownership of joint credit card • Joint mortgage or lease • Evidence of a joint obligation on a loan • Mutually granted durable power of attorney • Affidavit by a creditor able to testify to the partner's financial interdependence • Or other proof establishing economic interdependence
CHILDREN	Your children under age 26	**Biological Child –** A photocopy of the child's birth certificate showing your name as the parent and their Social Security Card. **Step Child** – A photocopy of the child's birth certificate showing the name of your spouse or partner as parent **and** a photocopy of your marriage certificate and the child's Social Security Card. **Legal Guardian or Adoption** – Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, or Adoption Final Decree with the presiding judge's signature and seal, and a photocopy of the child's Social Security Card.

** NOTE: For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

02/2021