LAST NAME		DISTRICT	
FIRST NAME		SOCIAL SECURITY NUMBER	

LAKE ERIE REGIONAL COUNCIL 1885 Lake Avenue, Elyria, Ohio 44035 440-324-5777 Fax: 440-324-4485

INSURANCE ENROLLMENT FORM-Please return to your district office

STREET ADDRESS		CITY		ZIP CODE	

BIRTH DATE		SEX		DATE OF HIRE		EFFECTIVE DATE OF COVERAGE	

STATUS	SINGLE		MARRIED		MARRIAGE DATE		DIVORCED		WIDOWED		PHONE	

DEPARTMENT Does not apply to Lorain, Vermilion	ADMINISTRATIVE		CERTIFIED		CLASSIFIED		ADMIN-principal, superintendent, treasurer etc… CERTIFIED-teachers etc… CLASSIFIED-bus drivers, lunch room, etc…

MEDICAL PLANS	SINGLE	FAMILY	DECLINE	ADDITIONAL MEDICAL PLANS Please note all schools do not offer these plans	SINGLE	FAMILY	DECLINE
PREMIUM PLAN ALL DISTRICTS				STANDARD PLAN *CLEARVIEW, COLUMBIA, KEYSTONE, LORAIN*			
MINIMUM VALUE PLAN (High Deductible Plan) ALL DISTRICTS				BASIC PLAN *COLUMBIA KEYSTONE, LORAIN*			
DENTAL PLANS	SINGLE	FAMILY	DECLINE	VISION PLANS	SINGLE	FAMILY	DECLINE
DELTA DENTAL PPO All districts except those listed below				EYEMED All districts except those listed below AMHERST HAS NO VISION PLAN			
DENTAL A PPO-AMHERST DENTAL A 2000.-LORAIN				MMO STANDARD VISION *ESC AND KEYSTONE ONLY*			
DENTAL B EPO-AMHERST DENTAL B-1000-LORAIN							

I would like to cover the following dependents:

DEPENDENT	LAST NAME	FIRST NAME	DOB	SEX	SS#	MED	DEN	VIS
SPOUSE								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								
DEPENDENT								

DOES SPOUSE WORK FOR A LERC SCHOOL DISTRICT?		DISTRICT NAME	

Are you or any dependent on Medicare?	YES		NO		MEDICARE POLICYHOLDER	

If you and/or your spouse are on Medicare but have coverage through LERC, your group health plan is primary and Medicare is secondary.

EMPLOYEE SIGNATURE		DATE	

By signing I agree that I received a HIPAA Notice of Special Enrollment Rights Statement

TREASURER/DESIGNEE SIGNATURE		DATE	

Please note that birth certificates, marriage certificates and Social Security Card copies may be requested when necessary.

LAKE ERIE REGIONAL COUNCIL

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OTHER INSURANCE COVERAGE

Complete this form IF your spouse/dependents have OTHER coverage including other LERC Plans.

EMPLOYEE FIRST NAME		EMPLOYEE LAST NAME		SOCIAL SECURITY	

CLAIMS WILL NOT BE PAID IF YOU DO NOT CONFIRM OR DENY OTHER INSURANCE FOR YOUR DEPENDENTS

My dependents have no other coverage	YES		NO	

OTHER CARRIER INFORMATION	
INSURANCE CARRIER	
EMPLOYER	
NAME OF INSURED	
POLICY NUMBER	
EFFECTIVE DATE	
CANCELLED DATE	

LIST INDIVIDUALS COVERED UNDER THE OTHER PLAN AND SELECT PLAN COVERAGE (Medical/Dental/Vision/Prescription)

DEPENDENT	LAST NAME (if different)	FIRST NAME	MED/RX	DENTAL	VISION	INSURANCE PROVIDER NAME
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

EMPLOYEE SIGNATURE		DATE	