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**	

MEDICAL PLANS	**SINGLE**	**FAMILY**	**DECLINE**	**ADDITIONAL MEDICAL PLANS** Please note all schools do not offer these plans	**SINGLE**	**FAMILY**	**DECLINE**
PLAN 1 ALL DISTRICTS EXCEPT FIRELANDS				PLAN 2 *ALL DISTRICTS EXCEPT ESC, JVS, VERMILION*			
MINIMUM VALUE PLAN (Affordable Care Act) ALL DISTRICTS				CDHP PLAN *ALL DISTRICTS EXCEPT ESC, JVS, VERMILION*			
DENTAL PLANS	**SINGLE**	**FAMILY**	**DECLINE**	**VISION PLANS**	**SINGLE**	**FAMILY**	**DECLINE**
DELTA DENTAL PPO ALL DISTRICTS EXCEPT AMHERST/LORAIN				EYEMED All DISTRICTS			
AMHERST DENTAL A PPO				LORAIN DENTAL A 2000			
AMHERST DENTAL B EPO				LORAIN DENTAL B 1000			

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								

DOES YOU SPOUSE WORK FOR ANOTHER SCHOOL DISTRICT?		**DISTRICT NAME**	

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

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, spousal forms and Social Security Card copies may be requested when necessary.

LERC

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	

Office of the Treasurer

LORAIN CITY SCHOOLS
Administration Center
2601 Pole Avenue, Lorain, OH 44052
440.830.4026 fax 440.233.2228

LCS Mandatory Spousal Rule

Mandatory Spousal Coverage: Lorain City Schools require that if your spouse is eligible to participate in their employers group health insurance and/or prescription drug plan, **it is mandatory that** your spouse enroll in such employer-sponsored or retirement group insurance coverage. Any spouse who fails to enroll in any such employer group insurance coverage shall be ineligible for benefits under group insurance coverage sponsored by LCS.

**Your spouse's employer must complete the spousal eligibility form to determine eligibility.

SPOUSE ELIGIBILITY CERTIFICATION for Health Insurance
Lorain City Schools
a member of Lake Erie Regional Council (LERC) *September, 2022*

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE/PLAN PARTICIPANT – PLEASE PRINT

EMPLOYEE/PLAN PARTICIPANT INFORMATION:

_____ FULL NAME

___XXX-XX-_____ SOCIAL SECURITY NUMBER

SPOUSE/DOMESTIC PARTNER INFORMATION:

_____ FULL NAME

_____ DATE OF BIRTH

_____ SOCIAL SECURITY NUMBER

Please check appropriate information:___Not employed ____ Employed____ Retired _____ Other ____
(Please explain, ie. Laid-off) _____ Date _____
If not employed or retired STOP, sign below and return form. Otherwise, complete and have your spouse's employer/retirement plan, or your spouse if self-employed, complete all applicable sections of this form.

Is group health insurance or prescription drug insurance available to your spouse through his/her employment (whether as a current employee or retiree)?

_____ YES _____ NO

Regardless of your answer, your spouse must have his/her employer, or your spouse himself/herself if self-employed, complete the Employer Information on the next page.

The LCS requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance, your spouse must enroll in such employer-sponsored or retirement group insurance coverage(s). Any spouse who fails to enroll in any such group insurance coverage, as required by this Section, shall be ineligible for benefits under group insurance coverage sponsored by LCS.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive benefits through the LCS group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise LCS immediately (and not later than 30 days after any change in eligibility) if your spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer/retirement plan after the date you submit this Certification. Upon becoming eligible, your spouse must enroll in such insurance(s) and upon such enrollment by your spouse, the LCS group insurance will terminated.

If you submit false information in this Certification or fail to timely advise the LCS of a change in your spouse's eligibility for health insurance and/or prescription drug insurance, and such false information or such failure by you results in the provision of benefits to which your spouse is not entitled, you will be personally liable for reimbursement of benefits and expenses, including attorneys' fees and costs. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by the LCS.

If you submit false information in this Certification, you may be subject to disciplinary action by the LCS, up to and including termination of employment.

EMPLOYEE/PLAN PARTICIPANT CERTIFICATION:

I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE/PLAN PARTICIPANT AND SPOUSE INFORMATION IS CORRECT, and understand that, to ensure benefits are coordinated properly between employers, retirement plans, verification of the accuracy of information will be determined through audits. My spouse's employer, retirement plan and I may be contacted.

_____ _____
PLAN PARTICIPANT'S SIGNATURE & DATE (Required) **AREA CODE/PHONE NUMBER**

Lorain City Schools
EMPLOYEE/PLANPARTICIPANT NAME (PRINTED): _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE

YOUR
EMPLOYEE NAME: _____ (spouse of LCS employee)

EMPLOYER: _____

EMPLOYER PHONE/ MAILING ADDRESS: _____

_____

Do you offer employer-sponsored group health insurance and/or prescription drug insurance (including, but not limited to, insurance requiring employee premium contributions):

(a) To employees? ____ YES ____ NO

(b) Is this employee eligible to participate? ____ YES ____ NO If no, explain why:

(c) Does the employee participate in your insurance plan? ____ YES ____ NO

HEALTH INSURANCE PLAN INFORMATION

PLAN/GROUP # _____ EFFECTIVE DATE OF COVERAGE (if enrolled): _____

INSURANCE COMPANY/TPA NAME: _____

MAILING ADDRESS: _____

EMPLOYER CERTIFICATION
I HEREBY CERTIFY THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

_____ _____
Spouse's Employer/Retirement Plan SIGNATURE **PRINTED NAME AND TITLE**

_____ _____ _____
AREA CODE/PHONE **EMAIL ADDRESS** **DATE**

Sandy Harrell, Benefits Coordinator Phone: 440-830-4052 ext or saharrell@loraincsd.org

ATTENTION Lorain City Schools Employees
PLEASE RETURN COMPLETED CERTIFICATION
TO Sandy Harrell- Benefits Coordinator-
TREASURER'S OFFICE.

LAKE ERIE REGIONAL COUNCIL

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HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days" or any longer period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.