Custom Design Benefits

Enrollment/Change Form

5589 Cheviot Road
Cincinnati, Ohio 45247
Fax: (513) 598-2913

Reason for Form

☐New Hire ☐ Open Enrollment ☐Name Change ☐Change Of Address ☐Add/Delete Dependent(s) ☐Termination

SECTION I – EMPLOYEE INFORMATION

Employer Name: **City of Oakwood** Division: Date Of Hire

Employee Name (**Last, First Mi**)

Social Security Number Date of Birth Sex

Street Address City State Zip Home Phone

Bank Name (complete page two to add or change bank; all vision payments will be reimbursed through this bank; checks are not available)

SECTON II – ENROLLMENT INFORMATION

Choose Vision Coverage: ☐Single ☐Employee & Spouse ☐Employee & Child/ren ☐Family

SECTION III – DEPENDENT INFORMATION (List family members eligible for coverage or affected by change)

Social Security Number	Date of Birth	Name (Last, First, MI)	Relationship Employee	Sex	F /T Student Y/N	Permanently Disabled Y/N	Add Y/N	Delete Y/N

SECTION IV – OTHER COVERAGE

Is your spouse employed? ☐Yes ☐ No Spouse's Employer: _____

Is your spouse eligible for vision insurance with his/her employer: ☐Yes ☐ No

If yes, when will your spouse be effective with his/her own plan? _____/_____/_____

Do you or any of your dependents have vision coverage under any other plan? ☐Yes ☐No

If Yes: Vision Carrier Name: _____ Phone Number: (____) _____

Name of Certificate Holder:_____ Policy #: _____

Covered Member(s): _____

SECTION V – CHANGE REQUEST (Complete only if already an active member and change to policy is requested)

☐Change name from _____ to _____ Reason: ☐Marriage ☐Divorce

☐Remove Dependent ☐Add Dependent

☐Adoption/Legal custody of child ☐Birth of Child

☐Other: _____

Effective date of change: _____/_____/_____

SECTION VI– AUTHORIZATION FOR ENROLLMENT/CHANGE(S)

☐**Accept** I confirm that all of the information provided above is accurate to the best of my knowledge. I understand that knowingly providing false and/or misleading information may be subject to legal action and may result in loss of coverage. I authorize vision care providers to furnish Custom Design Benefits with all vision, admission and insurance records pertaining to me and my dependents. I understand that if my dependent(s) become ineligible for coverage that I must report the change to the appropriate person/department immediately. I understand that all claims paid for ineligible charges will be recovered. I understand that all reimbursements will be made through Direct Deposit and it is my responsibility to add or update this information.

☐**Decline** **I have been offered Vision coverage, through my Employer's plan and after consideration, have decided <u>NOT</u> TO TAKE ADVANTAGE OF THIS OFFER. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special enrollment provision.**

Authorization/Signature for Enrollment/Change(s) Date