GENESEE COUNTY WATER AND WASTE
INSURANCE ENROLLMENT/CHANGE/DELETION FORM

EMPLOYEE NAME_____ SOCIAL SECURITY LAST FOUR DIGITS: _____

ADDRESS_____ TELEPHONE # (_____) _____-_____

CITY/ZIP_____

ADDITION: (CIRCLE ONE): Marriage Birth Open Enrollment Dependent(s) Change

DELETION: (CIRCLE ONE): Divorce Open Enrollment Dependent(s) Change

OTHER: (CIRCLE ONE) Name/Address Change Other_____

	(check status)		
Effective Date _____/____/_____	**Single**	**Two-Party**	**Family**
BCBS Community Blue PPO			
Dental and Vision			

Name	Relationship	SEX M or F	SSN	DOB
	SELF			
	SPOUSE			
	Dependent			
	Dependent			
	Dependent			
	Dependent			

OPT OUT of Medical Insurance

☐ (Initials)
I voluntarily elect not to receive hospital/medical insurance coverage as an employee of Genesee County Division of Water & Waste Services, and agree to hold Genesee County harmless for any liability for not providing this coverage. I certify that I am covered, or that as of the commencement of the non-coverage I will be covered by the following hospital/medical insurance:

Name of Insurance: _____Group Number/Contract Number_____
(Attach Proof of Coverage)

PLEASE NOTE: All dependent coverage is subject to verification of eligibility.

I certify that I read the important information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the health care contract void and refuse all allowance of the benefits to any person under the contract.

_____ _____ _____
Subscriber's Signature (Do Not Print) DATE Employer Representative

Revised 3-28-13