Medical, Dental & Vision Forms

Return signed documents to isacc.ramirez@co.hays.tx.us or Mercedes.hinojosa@co.hays.tx.us or deliver to Hays County Human Resources – Hays County Government Center, Suite 1063 no later than **November 30, 2021**.

Complete Only if Adding or Changing Benefit:

Instructions for completing UHC Form (*Medical and Dental*)

1. Employee Information –
    a) Name, SSN, Gender, DOB, Address, Phone, Email and Tabacco Use

2. Dependent Information – *(Complete this section only if adding or changing dependent medical and/or dental)*
    a) Name, SSN, Relationship, DOB and Gender

3. Select “Medical Plan Option” and “Plan Type” *(i.e. Emp only, Emp + Spouse, etc.)*

4. Select “Dental Plan Option” and “Plan Type” *(i.e. Emp only, Emp + Spouse, etc.)*

5. Waiver of Coverage (*complete this section only if waiving Medical and/or Dental*)

6. Complete “Other Medical Coverage Information” (*on page 2 of enrollment form if applicable*)

7. Employee signature and date is required on page 2 even if waiving coverage.

Group Name: County of Hays
Group ID: 912772

Plan Name:
Choice Plus, Choice & Choice Plus HDHP w/HSA

OFFICE USE ONLY:
Date of full time Hire _____
Effective Date _____

Division _____
Dept. _____

UnitedHealthcare®

___ Open Enrollment
___ New Hire
___ Change

Reason for Change: (check one)
____ Status Change (PT to FT) ____ Return from Leave/Layoff ____ Marriage ____ Birth ____ Adoption (attach legal documentation)
____ Court ordered dependent (attach documentation) ____ Death ____ Divorce _____ Moved out of service area
____ Dependent reached max age ____ Other (describe) _____

EMPLOYEE INFORMATION:

Last Name:	First Name:	M.I.	SSN:	Gender:	DOB:
Mailing Address:	City:		State:	Zip:	
Phone:	e-mail:		**Tobacco Use? ..... □Yes □ No**		

DEPENDENT INFORMATION:

MEDICAL	DENTAL	Last Name, First Name M.I.	SSN	Relationship	DOB	Gender
☐ Add ☐Delete	☐Add ☐ Delete					
☐ Add ☐Delete	☐Add ☐Delete					
☐Add ☐Delete	☐Add ☐Delete					
☐Add ☐Delete	☐Add ☐Delete					
☐Add ☐Delete	☐Add ☐Delete					

MEDICAL:

Plan Option

___Choice Plus (Plan 1) ___Choice (Plan 2) ___Choice Plus HDHP w/HSA (Plan 3)

Plan Type

___Emp Only ___Emp + Spouse ___Emp + Child(ren) ___Emp + Family

DENTAL:

Plan Option

____Dental PPO ____DHMO - Facility#_____

Plan Type

___Emp Only ___Emp + Spouse ___Emp + Child(ren) ___Emp + Family

WAIVER OF COVERAGE:

I hereby WAIVE coverage for (check all that apply):

MEDICAL FOR: ___Myself ___My Spouse ___My dependent children **DENTAL FOR: ___Myself ___My Spouse ___My dependent children**

Reason for declining coverage:
_____Existence of other health coverage _____Spousal coverage _____Other Reason _____

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" which is included on this form.

Other Medical Coverage Information

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other Medical Health plan or policy including another United HealthCare Plan or Medicare?..... □Yes □No

If yes, Medicare ID or medical carrier name: _____ Start date: _____ End date, if applicable: _____

Covered member (check all that apply) ____**Myself** ____ **My Spouse** ____**My dependent children**

I confirm that the information I have provided on this form is complete and accurate.
I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description.
I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.
I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.
I acknowledge that I have received the "Important Information" statement which is included on this form.
Any person who, knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee Signature _____ Date _____

IMPORTANT INFORMATION:
In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials do not answer your questions. Further information is available at www.welcometouhc.com , 1-866-633-2446, or Hays County Human Resources.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
• We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
• We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage:

I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.
I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we)authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this form. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.
I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Medical Coverage and any attachments.
I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

Legal entities must be provided here
i.e. Group Medical Insurance provided by or through: United HealthCare of Florida, Inc.
United HealthCare Insurance Company

Instructions for completing Superior Vision Form

1. Employee Information –
    a) Name, SSN, Gender, DOB, Address, Phone and Email

2. Select "ELECTION" (*i.e. Emp only, Emp + Spouse, etc.)*

3. *Dependent Information –* ***(Complete this section only if adding or dropping dependent)***
    a) Name, DOB and Gender

4. Employee signature and date required if enrolling in vision coverage.

VISION INSURANCE

SUPERIOR VISION

Underwritten by National Guardian Life Insurance Company

Administered by:
Superior Vision Services
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

Enrollment / Change Form

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Group Name	Group Number	Location	Effective Date	Date of Hire
Hays County	27475			

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone
		( )	( )

Email Address	Cell Phone
	( )

ELECTION(S)

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waived due to other coverage	Waive
☐	☐	☐	☐	☐	☐

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)

	Sex	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? ☐Yes ☐No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No

Employee Signature: ______________________________ Date: ____________

Do you or any of your dependents have other vision insurance? ☐ Yes ☐ No

If yes, please give: Policyholder ____________ and Insurance Company ______________.
Declination of coverage must be accompanied by the Employee's signature above.

Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Instructions for completing Salary Redirection/Reduction Form

1. Employee Information Required –
    a) SSN, DOB, Phone, Employee Name, Mailing Address and Email

2. Read the information in the paragraph below "Employee Information"

3. Place a **" √ "** or **" X** " in the **pre-tax** or **after-tax** column next to the benefits that you have authorized payroll to deduct (If adding Dependent Group Term-Life, Texas Republic Life and Short-Term Disability, deduction must be **"After-Tax"**).

4. If electing to **"Pre-Tax"** qualifying benefit deductions, place your initials in the **1st** box on the lower right of the page.

5. If electing to have <u>all</u> premiums deducted **"After-Tax",** place your initials in the **2nd** box on the lower right of the page.

6. Employee must sign and date form.

HAYS COUNTY CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

Cafeteria Plan Year: January 1, 2022 – December 31, 2022

☐ Open Enrollment ☐ Newly Eligible Employee as of ____-____-____

Date of first deduction: _____-_____-_____ Payroll Mode: ☐Semi-monthly ☐Monthly

Social Security # _____ Date of Birth: _____

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address:_____ City: _____ State:_____ Zip code:_____

Department _____ Work Phone Number:_____

Work E-Mail: _____

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution amounts will be deducted from my paycheck by my employer. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to "employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution, except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Vision Care Insurance	_____	_____
Dental Insurance	_____	_____	Accident Insurance	_____	_____
			Hospital Confinement Indemnity	_____	_____
Group Life Insurance (if family, must be after-tax)			Personal Sickness Indemnity	_____	_____
▪ Dearborn National (term-life)	_____	_____	Cancer Insurance	_____	_____
			Critical Illness		_____
▪ Texas Life (whole)		_____	Short-Term Disability Insurance		_____
▪ Texas Republic Life (whole)		_____			_____

Required acknowledgement to participate in the Cafeteria Plan:

I certify that the features and benefits under the Cafeteria Plan have been explained to me completely. By Initialing, I acknowledge that I understand the *"Important Information Regarding Participation in the Cafeteria Plan"* on the back of this form and agree to be bound by those requirements and any other requirements of the Cafeteria Plan.

☐

Waiver of Pre-tax benefits under the Cafeteria Plan:

By initialing, I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan

☐

Employee's Signature: _____ **Date:** _____

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE CAFETERIA PLAN

I understand and agree to the following:

- Restrictions on Election Changes: On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a “change in status” occurs (as defined under the Plan and the Internal Revenue Code), and the change is caused by and consistent with the "change in status”.

- Commencement of Coverage and Status of Prior Elections: Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue.

- Use of Personal Information: In addition to and without limiting in any way the rights my employer. the Plan, their service provider and their respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider and their respective agents, employees, subcontractors and assign to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

- Effect of Pre-Tax Contributions on Benefits Payments: Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.