HEALTH CARE COVERAGE APPLICATION

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

STEP 1: Personal Information

Member Social Security Number

___ — ___ — ____

Beneficiary Social Security Number
(Only if you are applying for a survivor benefit)

___ — ___ — ____

First Name | MI | Last Name

STEP 2: Enrolling in OPERS Group Medical/Pharmacy Coverage

◯ **Yes** - I would like to enroll in the OPERS group medical/pharmacy coverage for me and my eligible dependents, if applicable. Please read the Step 2 instructions for more information regarding medical/pharmacy plan administrators for each individual situation.

If you and your dependents are enrolled in Medicare Parts A and B and are not re-employed in an OPERS-covered position, you do not need to complete this step. Instead, you will enroll in medical/pharmacy plans through the OPERS Medicare Connector. Skip to Step 4.

If re-employed, you must fill out Step 2 or Step 3.

STEP 3: Deferring OPERS Group Medical/Pharmacy Coverage

◯ **No** - I do not want to enroll in the OPERS group medical/pharmacy coverage, including dependent coverage, offered by OPERS. I have read the "Deferring enrollment in OPERS health care coverage" section of the *OPERS Health Care Coverage Guide* and understand my rights regarding enrollment in the OPERS medical/pharmacy coverage.

Recipient Signature _____ Date _____

STEP 4: Vision and Dental Options

I choose the following **Vision Coverage**. (Choose only one).

◯ **High Option** ◯ **Low Option** ◯ **None**

I choose the following **Dental Coverage**. (Choose only one).

◯ **High Option** ◯ **Low Option** ◯ **None**

STOP Please read instructions, Step 4. This option is not available for everyone. Once you enroll, you can enroll your spouse and/or child(ren) in Steps 6 and 7.

STEP 5: Medicare and Other Coverage Information

◯ **Yes** ◯ **No** Are you eligible for Medicare?
(If yes, please provide proof of Medicare coverage if you are re-employed and enrolling in our group plan.)

If you are under age 65 and eligible for Medicare Parts A and B, please mark the appropriate reason for your early Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis ___/___/____
(If yes, please provide proof of Medicare coverage.)

◯ **Kidney Transplant** Date of Transplant ___/___/____
(If yes, please provide proof of Medicare coverage.)

If you receive a benefit from another Ohio Retirement System(s), mark all that apply:

◯ **None** ◯ **SERS** ◯ **STRS** ◯ **OP&F** ◯ **HPRS**

STEP 6: Coverage for Spouse

1. Spouse First Name MI Last Name

Social Security Number ___-___-____ Gender ◯ Male ◯ Female Birth Date ___/___/____

Please enroll my spouse in the following health care coverage(s): (Choose all that apply.)

◯ **Medical/Pharmacy** ◯ **Vision** ◯ **Dental**

Does your spouse receive a benefit from another Ohio Retirement System(s)? (Mark all that apply.)

◯ **None** ◯ **SERS** ◯ **STRS** ◯ **OP&F** ◯ **HPRS**

Account Number ___-___-____

◯ **Yes** ◯ **No** Is your spouse eligible for Medicare?
(If yes, please provide proof of Medicare coverage if you are re-employed and enrolling in our group plan.)

If your spouse is under age 65 and eligible for Medicare Parts A and B, please mark the appropriate reason for their early Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis ___/___/____
(If yes, please provide proof of Medicare coverage.)

◯ **Kidney Transplant** Date of Transplant ___/___/____
(If yes, please provide proof of Medicare coverage.)

STEP 7: Coverage for Children

1. Child First Name MI Last Name

Social Security Number Gender Birth Date

___-___-____ ◯ Male ◯ Female __/__/____

Please enroll this child in the following health care coverage(s): (Choose all that apply.)

◯ **Medical/Pharmacy** ◯ **Vision** ◯ **Dental**

◯ **Yes** ◯ **No** Is your child eligible for Medicare Parts A and B?
(If yes, please provide proof of Medicare coverage if you are re-employed and enrolling in our group plan.)

Please mark the appropriate reason for Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis __/__/____
(If yes, please provide proof of Medicare coverage.)

◯ **Kidney Transplant** Date of Transplant __/__/____
(If yes, please provide proof of Medicare coverage.)

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2. Child First Name MI Last Name

Social Security Number Gender Birth Date

___-___-____ ◯ Male ◯ Female __/__/____

Please enroll this child in the following health care coverage(s): (Choose all that apply.)

◯ **Medical/Pharmacy** ◯ **Vision** ◯ **Dental**

◯ **Yes** ◯ **No** Is your child eligible for Medicare Parts A and B?
(If yes, please provide proof of Medicare coverage if you are re-employed and enrolling in our group plan.)

Please mark the appropriate reason for Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis __/__/____
(If yes, please provide proof of Medicare coverage.)

◯ **Kidney Transplant** Date of Transplant __/__/____
(If yes, please provide proof of Medicare coverage.)

For additional dependent children, please attach a separate sheet with this application and include the same information as requested for the other children.

Please Note: Complete this form by reading and signing Step 8 on the reverse side.

STEP 8: Acknowledgment

By enrolling in OPERS health care coverage, I acknowledge that OPERS and my chosen health care vendor may have contact with each other, including the sharing of my personal health information, for purposes of administering my coverage.

I acknowledge that the information provided on this form is true and the enrolled dependents are eligible for coverage, as defined by Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. I acknowledge that it is my responsibility to notify OPERS within 30 days of a dependent becoming ineligible for coverage and that I will be responsible for all overpaid claims resulting from my failure to notify OPERS. I acknowledge my premium for health care coverage will be deducted from my monthly OPERS pension benefit. If my monthly OPERS benefit is less than the amount to cover the full cost of my health care premium, my entire OPERS benefit will be applied as payment toward my health care premium. OPERS will then bill me for any remaining amount.

I acknowledge that I am required to enroll in Medicare Parts A and B upon becoming eligible. I acknowledge that I may be eligible for reimbursement of Medicare A premiums if offered by the OPERS Board of Trustees in lieu of a plan that covers hospital costs similar to Medicare A. I will notify OPERS immediately if I become ineligible for Medicare A or B reimbursement. I am responsible for any overpayment of the Medicare Part A premium reimbursement.

I acknowledge that if I am applying for a disability benefit or have been approved for a disability benefit, I have read the disability section of the *OPERS Health Care Coverage Guide*. I understand and acknowledge that my access to health care is contingent on my continued eligibility for and receipt of a disability benefit. I also understand that my access to health care coverage will be limited to the first five years of my disability benefit. If my disability benefit continues beyond five years, I understand and acknowledge that I will be required to meet OPERS health care eligibility rules or be under age 65 and enrolled in Medicare in order to continue to have access to health care coverage from OPERS.

I acknowledge there is no promise, guarantee, contract or vested right to access to health care coverage or a premium allowance. The OPERS Board of Trustees has the discretion to review, rescind, modify or change the health care plan at any time.

Recipient Signature _____ Date ____/____/____

Do not print or type name