Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642

1-800-222-PERS (7377) www.opers.org

Application for Vision and/or Dental Coverage

Enrollment in the OPERS Vision and/or Dental Plan must be for the entire calendar year. Complete this form if you wish to enroll in, cancel or change your vision and/or dental coverage options.

Section 1 - Personal Information

Provide all personal information in this section.

Member Social Security Number

Beneficiary Social Security Number *(if receiving a survivor benefit)*

Date of Birth **Month** **Day** **Year**

First Name **MI** **Last Name**

Street or Mailing Address

City **State** **ZIP Code** -

Section 2 - Spouse and Dependent Enrollment

Complete this Section if you wish to enroll your eligible spouse and/or children in the OPERS vision and/or dental plans. Please review the dependent eligibility information in the OPERS Health Care Program Guide or the OPERS Vision and Dental Plan Guide to determine if your spouse and/or children are eligible. You must certify your spouse and/or your children's eligibility for coverage at the end of this form and notify OPERS within 30 days of any change in their eligibility. You are responsible for any claim overpayment resulting from your failure to notify OPERS that your spouse and/or child(ren) has become ineligible for vision or dental coverage.

Spouse First Name **MI** **Last Name**

Date of Birth **Month** **Day** **Year**

Gender **Male** **Female** **Prefer Not to Say**

Social Security Number

1. Child First Name **MI** **Last Name**

Date of Birth **Month** **Day** **Year**

Gender **Male** **Female** **Prefer Not to Say**

Social Security Number

2. Child First Name **MI** **Last Name**

Date of Birth **Month** **Day** **Year**

Gender **Male** **Female** **Prefer Not to Say**

Social Security Number

Please attach another sheet for any additional children and provide all of the information requested above for each child.

Section 3 - Vision and Dental Coverage Enrollment/Change

I elect VISION coverage in the:

☐ **High Option** ☐ **Low Option**

I elect this VISION coverage for:

☐ **Myself** ☐ **Spouse** ☐ **1 Child** ☐ **2+ Children**

Name of child(ren) being enrolled:_____

I elect DENTAL coverage in the:

☐ **High Option** ☐ **Low Option**

I elect this DENTAL coverage for:

☐ **Myself** ☐ **Spouse** ☐ **1 Child** ☐ **2+ Children**

Name of child(ren) being enrolled:_____

Section 4 - Auto-Reimbursement from your HRA for Vision and Dental Premiums

If you are eligible for a Health Reimbursement Arrangement (HRA), the OPERS vision and/or dental premium(s) deducted from your monthly benefit payment will automatically be reimbursed from your HRA, if funds are available. After you receive your first reimbursement, you can view and/or update your automatic reimbursement preference by logging into your account at marketplace.viabenefits.com/opers and selecting "View Accounts" under the Funds & Reimbursement section or by contacting Via Benefits at 1-844-287-9945.

Section 5 - Cancellation of Current Coverage

I elect to cancel the following coverage for myself: ☐ **Vision** ☐ **Dental**

Canceling coverage for yourself will automatically cancel coverage for any enrolled dependents.

I elect to cancel the following coverage for my spouse: ☐ **Vision** ☐ **Dental**

If you are canceling coverage because your spouse is no longer eligible, please indicate the date of ineligibility _____

I elect to cancel the following coverage for my child(ren): ☐ **Vision** ☐ **Dental**

Name of child(ren):_____

Section 6 - Acknowledgment and Authorization

Please read the following acknowledgment carefully. ***Sign and date the form before returning it to OPERS.***

If I am enrolling dependents, I acknowledge that the information provided on this form is true and accurate and the enrolled dependents are eligible for coverage, as defined in the OPERS Health Care Program Guide or the OPERS Vision and Dental Plan Guide and the applicable federal laws regarding dependent coverage. I acknowledge that it is my responsibility to notify OPERS within 30 days of a dependent becoming ineligible for coverage.

I authorize the appropriate premium (if applicable) for the coverage I am requesting, including dependent coverage (if applicable), to be deducted from my OPERS benefit payment. If my monthly OPERS benefit payment is less than the amount to cover the full cost of my premium(s), my requested enrollment(s) in the plan(s) will not be accepted.

I authorize Automatic Premium Reimbursement of vision and dental premiums. I confirm that the premiums were for covered participants while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. If I wish to update my automatic reimbursement preferences, I know I must do so through the OPERS Connector.

Today's Date

Month **Day** **Year**

Recipient Signature_____ ☐☐ ☐☐ ☐☐☐☐

Do not print or type name