HEALTH CARE COVERAGE: CHANGE OF COVERAGE

OPERS
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 receiving a survivor benefit)

___ — __ — ____

◯ **Yes** ◯ **No** Are You Legally Married?

STEP 2: Coverage for Spouse

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)? (If yes, please 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 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 __ / __ / ____

◯ **Kidney Transplant** Date of Transplant __ / __ / ____

STEP 3: Coverage for Children

1. Child First Name | MI | Last Name

Social Security Number ___ — __ — ____

Gender ◯ Male ◯ Female

Birth Date __ / __ / ____

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.)

STEP 3: Coverage for Children *(continued)*

Please mark the appropriate reason for their Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis ___ / ___ / ____

◯ **Kidney Transplant** Date of Transplant ___ / ___ / ____

2. Child First Name MI Last Name

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

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.)

Please mark the appropriate reason for their Medicare eligibility:

◯ **Disability through Social Security**

◯ **End Stage Renal Disease** Date of First Dialysis ___ / ___ / ____

◯ **Kidney Transplant** Date of Transplant ___ / ___ / ____

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

STEP 4: Vision and Dental Options

As a recipient, you may be eligible to enroll in these plans. Refer to the instructions in Step 4.

Vision Coverage

I choose the following Vision Coverage level for me and my dependents, if applicable. (Choose only one.)

◯ **HIGH Option** ◯ **LOW Option**

Dental Coverage

I choose the following Dental Coverage level for me and my dependents, if applicable. (Choose only one.)

◯ **HIGH Option** ◯ **LOW Option**

STEP 5: Acknowledgment

I authorize the changes to my health care coverage that I have indicated in this form. If I am enrolling my dependents, I acknowledge that the information I provided is true and the dependents I enroll are eligible for coverage, as defined by Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. I understand that it is my responsibility to notify OPERS within 30 days if a dependent becomes ineligible for coverage and that I am responsible for any 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 understand my dependents are required to enroll in Medicare Parts A and B upon becoming eligible. I understand I am responsible for any overpayment of the Medicare A premium reimbursement. 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