NORTHERN BUCKEYE EDUCATION COUNCIL
ACCESS+ PLAN
ENROLLMENT FORM

For NBEC Administrative Use Only

PLAN #	LOCATION	STATUS		EFFECTIVE DATE	VERIFIED BY
AP-1	NSA	A			

PLAN NAME	CLIENT #	REASON FOR TERMINATION/TYPE OF CHANGE:
Northern Buckeye Education Council	**817**	☐ NEW ENROLLMENT ☐ CHANGE ☐ COBRA ☐ TERMINATE

EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYER	DATE OF HIRE	EFFECTIVE DATE
	NW STATE COMMUNITY COLLEGE		

EMPLOYEE NAME

EMPLOYEE STREET ADDRESS

CITY STATE ZIP

COVERAGE TYPE : ☐ Employee ☐ Family

ARE YOU OR ANY OF YOUR DEPENDENTS, ON THIS POLICY, COVERED BY ANOTHER HEALTH INSURANCE PLAN? ☐ Yes ☐ No

If yes, you must complete the Coordination of Benefits form.

COUNTY

NAME	GENDER	BIRTH DATE	SOCIAL SECURITY NO.	TERMINATION DATE
EMPLOYEE	☐ MALE ☐ FEMALE			
SPOUSE	☐ MALE ☐ FEMALE			
CHILD	☐ MALE ☐ FEMALE			
CHILD	☐ MALE ☐ FEMALE			
CHILD	☐ MALE ☐ FEMALE			
CHILD	☐ MALE ☐ FEMALE			
CHILD	☐ MALE ☐ FEMALE			

AUTHORIZATION SIGNATURE (Must be completed by ALL covered persons age 18 or older)

I ACKNOWLEDGE THAT ANY PROVIDERS OF HEALTH CARE SERVICES, SUPPLIERS, CLAIM ADMINISTRATORS, INSURERS, REINSURERS, PLAN SPONSOR AND ITS AGENTS AND ANY OTHERS WHO HAVE A LEGITIMATE NEED FOR SUCH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OTHER HEALTH CARE OPERATIONS, SHALL SUPPLY EACH OTHER WITH INFORMATION ABOUT MY HEALTH STATUS AND HEALTH CARE SERVICES PROVIDED TO ME, INCLUDING BUT NOT LIMITED TO MY MEDICAL RECORDS. IF APPLICABLE, I AGREE TO REIMBURSE THE PLAN TO THE EXTENT OF ANY PAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THIS PLAN. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

☐ ACCEPTANCE OF ENROLLMENT

I understand, in order for the Plan to accept or decline this application, all of the information requested on the enrollment form must be completed. In the event that I have not correctly or fully completed this enrollment form, my signature shall authorize the Plan or their designees to obtain the necessary information for me and to complete that information on this enrollment form and application. I acknowledge that the cost management features of this coverage (such as pre-certification and utilization review), as well as benefits coverage under the Plan, have been provided to me. I certify that I have received a Master Plan Document and that all information I have provided is true and complete to the best of my knowledge. I understand that any misrepresentation or significant omission may void my coverage. I also understand that any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I agree to immediately report any changes to any of the information included on this or the Coordination of Benefits form. If applicable, I authorize my employer to deduct the required premium contributions from my pay.

☐ WAIVER OF ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that if I wish to enroll at a later date, I may be required to submit satisfactory evidence of good health at that time. The Benefits have been explained to me thoroughly. Unless otherwise indicated above, I DO NOT wish to enroll and understand that I will not be entitled to any benefits provided by the Plan.

SIGNATURE DATE

All enrollment forms must be completed and returned to your school's Human Resources office.