Medical Mutual Insurance Enrollment--EMPLOYEE-ONLY AND EMPLOYEE PLUS CHILD(REN)

Return form to Lake County Board of DD/Deepwood Human Resources Department

Group Name: Lake County Board of DD/Deepwood   Group Number 635401
Employee is to complete sections A, B, and C and then sign at bottom of page.

A. EMPLOYEE INFORMATION

FIRST NAME		M. I.	LAST NAME		
STREET ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE NUMBER, WITH AREA CODE			DATE INSURANCE IS EFFECTIVE		
DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER		DATE OF EMPLOYMENT		
OCCUPATION	HOURS WORKED PER WEEK		GENDER: M F		

B. CHILDREN INFORMATION--Must provide ALL documentation per Agency policy on reverse side

If you are adding child(ren) to your plan, you must provide the Social Security number(s).

CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTH DATE (MM/DD/YY)	GENDER
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTH DATE (MM/DD/YY)	GENDER
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTH DATE (MM/DD/YY)	GENDER
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTH DATE (MM/DD/YY)	GENDER

PLEASE INDICATE YOUR CHOICE OF PLAN BELOW:

X____________ I elect the PPO Plan, or:

X____________ I elect the HDHP (High Deductible) Health Plan (HSA)

C. OTHER MEDICAL INSURANCE COVERAGE

If you or any dependent listed on this app has other group medical insurance, please provide the following:

Name(s) of person(s) covered	Effective date of other coverage	Name of other medical insurance

D. AUTHORIZATION

Any person who, with 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.

INSURED'S SIGNATURE **X**	DATE

Please see LCBDD Group Insurance Dependent Documentation Requirements (Documentation must be attached for EACH dependent to be covered)

NOTE: There is a separate application for enrolling spouses. It must be completed and returned along with the appropriate notarized Spousal Surcharge Affidavit.