STRS OHIO HealthCare PROGRAM

275 East Broad Street
Columbus, OH 43215-3771
888-227-7877
614-233-8713 (fax)
www.strsoh.org

ENROLLMENT APPLICATION FOR HEALTH CARE COVERAGE

For STRS Ohio's Medical, Dental and Vision Plans

Read ***Eligibility and Enrollment Guidelines for Health Care Coverage*** before completing this application. Please print all information.

For quicker service, you can apply for coverage through your Online Personal Account. If you are a new benefit recipient, beneficiary or survivor, you can request coverage when you submit your online application for benefits. If you want to enroll during open enrollment or due to a qualifying event, you can request coverage through the Health Care section of your personal account.

Note: *Coverage under the STRS Ohio Health Care Program is not guaranteed. Eligibility rules, premiums, copayments/coinsurance, deductibles and all other charges or fees paid by an enrollee may change at any time.*

Part 1 — Benefit Recipient Information

Benefit recipient's Social Security number or STRS Ohio account number _____

Benefit recipient's name _____
First Middle initial Last

Home address _____
Street City State ZIP code

Home phone (_____)_____ Cell phone (_____) _____
Area code Area code

Email address _____ Date of birth _____/_____/_____
Month Day Year

Reason for Enrolling *(Select one)*	Required Documentation
❑ I am a new service retirement or disability benefit recipient.	None
❑ I am a new beneficiary or survivor who was a spouse, child or disabled adult child of the member when the member died.	None
❑ I want to enroll during open enrollment.	None
Qualifying Event	
❑ Initial eligibility for and enrollment in Medicare Parts A & B or Part B-only.	Copy of your Medicare card
❑ Loss of other coverage. Date coverage terminated: ____/____/_____	Proof of prior creditable coverage document/letter
❑ Spouse is being added because of marriage. Date of marriage: ____/____/_____	Copy of your marriage certificate
❑ Child is being added because of birth, adoption or legal guardianship. Date event occurred: ____/____/_____	Copy of the birth certificate or adoption or guardianship papers

(continued)

Please answer all questions below.

1. Are you currently covered by, or will you become eligible for, health care coverage through one of the Ohio public retirement systems?

   ❑ Yes ❑ No *If yes, which system?*

   ❑ Highway Patrol Retirement System
   ❑ Ohio Police & Fire Pension Fund
   ❑ Ohio Public Employees Retirement System
   ❑ School Employees Retirement System
   ❑ STRS Ohio

2. Are you employed and eligible for health care coverage through your employer?

   ❑ Yes ❑ No *If yes — and you are not eligible for Medicare — you may be eligible for only secondary coverage with STRS Ohio.*

3. Are you currently eligible for Medicare?

   ❑ Yes ❑ No *If yes, you must submit a copy of your Medicare card.*

Part 2 — Eligible Dependent Information

Provide information below for the eligible dependents you request to enroll. If any covered family members are eligible for Medicare Parts A & B or Part B-only, you must submit a copy of their Medicare card with the benefit recipient's STRS Ohio account number noted.

Please provide required information below.

1. Is any dependent currently covered by, or will any dependent become eligible for, health care coverage through one of the Ohio public retirement systems?

   ❑ Yes ❑ No *If yes, list dependent's name and retirement system:*

   Name _____ Retirement system _____

2. **SPOUSE** (Beneficiaries and survivors may not enroll a new spouse.)

Name	Gender	Social Security number *(Required)*	Date of birth *(Month/Day/Year)*	Eligible for Medicare at this time?
	❑ Male ❑ Female			❑ Yes ❑ No

3. **CHILDREN** (Only children of the service retirement benefit recipient, disability benefit recipient or deceased active member may be enrolled.)

Name	Gender	Social Security number *(Required)*	Date of birth *(Month/Day/Year)*	Is the child biological, legally adopted, a stepchild or under your guardianship?*	Eligible for Medicare at this time?
	❑ Male ❑ Female			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Male ❑ Female			❑ Yes ❑ No	❑ Yes ❑ No

*If you answered "Yes," supporting documentation may be required. If you answered "No," the child is not eligible for STRS Ohio coverage.

4. **DISABLED ADULT CHILD** (Call STRS Ohio to begin the eligibility determination process.)

Name	Gender	Social Security number *(Required)*	Date of birth *(Month/Day/Year)*	Eligible for Medicare at this time?
	❑ Male ❑ Female			❑ Yes ❑ No

Part 3 — Enrollment/Plan Selection

Contact STRS Ohio for your plan options and premiums. You can also view this information in your Online Personal Account. If you do not make a medical plan selection, you will be enrolled in the Aetna Basic Plan. Eligible family members only qualify for coverage if the benefit recipient is enrolled in the plan or is also requesting enrollment. Complete the following information for each individual you want to enroll.

Enrollee's name	Medical coverage	Name of medical plan selected	Dental coverage	Vision coverage
Self (benefit recipient):	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No
Spouse:	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No
Child:	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No
Child:	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No
Disabled adult child:	❑ Yes ❑ No		❑ Yes ❑ No	❑ Yes ❑ No

Part 4 — Demographic Information for Medicare Enrollees

Centers for Medicare & Medicaid Services (CMS), part of the U.S. Department of Health & Human Services, requires STRS Ohio to offer Medicare plan enrollees the opportunity to indicate race and ethnicity.*

Please provide the race and ethnicity for each family member enrolling in an STRS Ohio Medicare plan using the selections below. Providing this information is your choice. You may choose not to answer for yourself and/or any family members. No enrollee will be denied coverage if you choose not to answer.

Race			Ethnicity
What is your race? Select all that apply.			Are you of Hispanic, Latino or Spanish origin?
• American Indian or Alaska Native	• Asian Indian	• Black or African American	**If no, select:**
• Chinese	• Filipino	• Guamanian or Chamorro	• Not of Hispanic, Latino or Spanish origin
• Japanese	• Korean	• Native Hawaiian	**If yes, select:**
• Other Asian	• Other Pacific Islander	• Samoan	• Puerto Rican
• Vietnamese	• White	• I choose not to answer	• Another Hispanic, Latino or Spanish origin
			• Mexican, Mexican American or Chicano
			• Cuban
			• I choose not to answer

Enrollee's name	Race	Ethnicity
Self (benefit recipient):		
Spouse:		
Disabled adult child:		
❑ I choose not to answer for myself and all family members.		

*CMS is committed to addressing health inequities and underlying inequities within the health care system. CMS requests this information to better understand the diversity of the Medicare population, including important differences in health and health care needs/experiences across race and ethnicity groups.

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Part 5 — Additional Information

Please submit any additional required information with this application. Failure to do so may prevent your enrollment in a plan. You will be notified of the effective date of coverage for you and/or your eligible dependents. Be aware, Medicare enrollment is required for all medical plan participants who are age 65 or older, or otherwise eligible for Medicare. Proof of Medicare coverage is required. Also, early contract cancellation is not permitted under the dental and vision plans. You must continue to pay monthly premiums through the end of the current two-year contract period even if you no longer need or use services under the plan.

I certify the information I have provided is true and correct. Upon enrollment, I and any covered dependents authorize the release of all information to STRS Ohio and its designees for use in the administration of its health care plan.

Benefit recipient's signature _____ **Date** _____/_____/_____
Month Day Year