

714 Washington St.
Toledo, OH 43604

Any forms *not* on file by January 31st, 2010 will result in **NONPAYMENT** of ALL medical & dental claims submitted. Claims will be denied and will NOT be reconsidered for payment. Payment will be the member's responsibility.

NO EXCEPTIONS

INITIAL

TO BE COMPLETED BY APPLICANT - PLEASE PRINT OR TYPE

Last Name	First Name	M.I.	Social Security Number	Date of Birth / /
Street Address		City	State	Zip Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone No. ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		

SPOUSE INFORMATION

Spouse	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Health Insurance offered to your spouse through employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is insurance offered at a cost? <input type="checkbox"/> Yes <input type="checkbox"/> No		Single Coverage Weekly Cost \$ _____ Monthly Cost \$ _____		Family Coverage Weekly Cost \$ _____ Monthly Cost \$ _____
What Type of Coverage is offered to your spouse? <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision <input type="checkbox"/> Dental						
Is your spouse currently enrolled in Employers Health Insurance Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF YES PLEASE COMPLETE BELOW)				Type of Coverage Enrolled In <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Effect. Date of Coverage
Policy Holders Name and Date of Birth			Health Insurance Co.		Address	
Policy Number	Phone Contact No.	Effective Date of Policy	Type of Coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee/ Spouse <input type="checkbox"/> Employee/ Children <input type="checkbox"/> Family			

DEPENDENT INFORMATION

Child 01	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						
Child 02	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						
Child 03	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						
Child 04	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						
Child 05	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						
Child 06	Last Name	First Name	M.I.	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Please check child's relationship to employee: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other						

(over)

NOTE: If you are claiming a dependent on this form as a result of divorce, adoption, court order, or your dependent is from a spouse's previous marriage, you must submit documentation to the Health Plan in the form of a court order, proof of support, copy of divorce decree or legal adoption papers. Dependent coverage will not be considered without this information!

_____ Initials

COLLEGE STUDENT STATUS

Dependent children are covered under the Health Plan until age 19 unless they are attending a college or university full time. Coverage is then extended until age 23 or upon graduation. (Full Time consists of 12 or more credit hours).

Dependent Name	Social Security Number
College/University	Expected Date of Graduation

DEATH BENEFIT INFORMATION

I hereby designate the following beneficiary(ies) for my \$20,000 death benefit from the Toledo Firefighters Health Plan:

Primary _____ %

Contingent (if all above are deceased) _____ %

Date

Employee Signature

I authorize any hospital or physician to furnish Toledo Firefighters Health Plan such medical information as it may require for myself and dependents. I authorize Toledo Firefighters Health Plan to conduct a professional and utilization review program of health services on behalf of myself and dependents and to coordinate benefits and /or reimbursements with other health or insurance companies. This certifies that the above information is correct to the best of my knowledge and belief. Any firefighter or spouse who violates any aspect of these rules, including, but not limited to, not promptly and accurately filing the annual enrollment form, not keeping the Fund office promptly advised of all changes in family status or employment, not complying with the terms and conditions of the spouse's insurance plan or making false or fraudulent statements to the Fund shall:

1. not be eligible for future benefits under this plan; and
2. be obligated to repay to the Fund any monies paid out by the Fund because of the false or fraudulent information provided.

The Health Plan reserves the right to request dependent and/or employee information at any time. Enrollment in the Health Plan is required every year.



Date

RETURN TO:
Health Plan Office,
NO LATER THAN
January 31, 2010

Employee Signature