Dental & Vision Election Form

The open enrollment period is the month of November with an effective date of January 1st the following year. You may also change coverage if you experience a qualifying event. You have sixty (60) days after the event to notify HPRS of the change. Qualifying coverage based upon a marriage, birth, or adoption will be effective on the date of that event.

☐ **Open Enrollment/New Applicant** ☐ **Qualifying Event***

*If you have experienced a qualifying event (e.g., marriage, divorce, change in job status, birth, adoption, guardianship), please list:

Event: _____ **Date event occurred:** _____

Section 1 - Personal Information - *This section is to be completed by the retiree, surviving spouse or surviving child.*

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Gender: ☐ Male ☐ Female

City _____ State _____ Zip Code _____

XXX-XX- _____ SSN _____ DOB _____ Home Phone *(if applicable)* _____

Email Address _____ Cell Phone _____

Marital Status *(Single, Married, Divorced, Widowed)* _____ Marriage Date *(if applicable)* _____ Divorce Date *(if applicable)* _____

Section 2 – Selecting Coverage

Complete this section to select coverage for yourself and/or your dependents. *Include a copy of dependents birth certificate.*

Full Name	SSN	Relationship	Date of Birth	Gender	Coverage to be selected
		SELF		☐ MALE ☐ FEMALE	☐ VISION ☐ DENTAL
				☐ MALE ☐ FEMALE	☐ VISION ☐ DENTAL
				☐ MALE ☐ FEMALE	☐ VISION ☐ DENTAL
				☐ MALE ☐ FEMALE	☐ VISION ☐ DENTAL
				☐ MALE ☐ FEMALE	☐ VISION ☐ DENTAL

Section 3 – Signature and Acknowledgement

The completion and submission of this form constitutes providing information for the purpose of obtaining a benefit from a public agency. Providing false information is a criminal offense under the Ohio Revised Code.

I understand data from this form will be used by the Highway Patrol Retirement System and its vendors for the purpose of evaluating and administering claims. I agree that any premiums for coverage will be deducted from my monthly pension payment.

I understand I must notify HPRS within sixty (60) days of changes in my status including, but not limited to, divorce, marriage, death, birth, or adoption.

I understand I may be liable for any claims that are incurred or paid based upon inaccurate information I have provided to HPRS.

My signature below affirms that all information provided on this form is complete and true to the best of my knowledge.

▶ _____ _____

Signature **Date**

HPRS Use Only:	New / Change / Waive	Retiree Last GXT:	_____
Effective Date:		By:	