Health Care 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. **Please refer to Section(s) 2 & 3 for dependent eligibility requirements.**

☐ **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)* ______

☐ **Check this box to waive ALL coverage, then sign and date on page 4**

A.) Election of Coverage – *Complete for New or Continued Coverage*

		HPRS Coverage Primary	HPRS Coverage Secondary
Medical/Prescription:	☐	☐	☐
Dental:	☐		
Vision:	☐		

B.) Have you used a tobacco product 4 or more times per week over the past 6 months? ☐ Yes ☐ No

C.) Are you eligible for Medicare? *(If yes, please include a copy of your Medicare card)* ☐ Yes ☐ No

IF YOU ARE A SURVIVING SPOUSE:

- **Do you have access to non-HPRS health care through employment, another pension plan, or another source?** ☐ Yes ☐ No

  If yes, please identify source of coverage: ______________________

- **Are you remarried?** ☐ Yes ☐ No

  If yes, do you have access to health care through your spouse? ☐ Yes ☐ No

Section 2 - Dependent Coverage for Spouse - *Complete this section if you wish to enroll your eligible spouse in medical/pharmacy, dental or vision plan(s).* ***Please submit a copy of marriage certificate.***

A spouse who has access to medical and/or prescription coverage through employment or another source must secure it as primary coverage, regardless of cost. A spouse receiving a payment, stipend, or other remuneration of any kind for the purpose of obtaining medical and/or prescription coverage may not elect HPRS health care for primary coverage.

Last Name ______ First Name ______ Middle Initial ______

SSN ______ DOB ______ Gender: ☐ Male ☐ Female

A.) Election of Coverage – *Complete for New or Continued Coverage*

		HPRS Coverage Primary	HPRS Coverage Secondary
Medical/Prescription:	☐	☐	☐
Dental:	☐		
Vision:	☐		

B.) Has your spouse used a tobacco product 4 or more times per week over the past 6 months? ☐ Yes ☐ No

C.) Does your spouse have access to non-HPRS health care through employment, another pension plan, or another source? ☐ Yes ☐ No

If yes, please identify source of coverage: ______

D.) Is your spouse eligible for Medicare? *(If yes, please include a copy of Medicare card)* ☐ Yes ☐ No

Section 3 - Dependent Coverage for Children - *Complete this section if you wish to enroll your eligible child(ren) in medical/pharmacy, dental or vision plan(s).* ***Please submit a copy of birth certificate, adoption certificate or proof of guardianship for each dependent child.***

A child who is eighteen (18) up to twenty-six (26) years of age is not an eligible dependent if he/she has access to any medical and/or prescription coverage through employment, a biological or step parent, a spouse, military service, or a college or university regardless of cost or residency. For the purpose of this division, access to medical and/or prescription coverage includes receiving a payment, stipend, or other remuneration of any kind. HPRS may confirm the dependents you enroll are eligible dependents according to the OAC 5505-7-04. Please attach additional sheet(s) if necessary for other children and provide the information requested below.

Dependent Child #1

Last Name ______ First Name ______ Middle Initial ______

SSN ______ DOB ______ Gender: ☐ Male ☐ Female

If age 18 or older, does this child have access to health care through any of the following?

☐ Employment ☐ Spouse ☐ Biological or Step-Parent ☐ Military ☐ College/University

STOP ***If any of the above are checked STOP HERE – this child is not eligible for HPRS coverage.***

A.) Election of Coverage – *Complete for New or Continued Coverage*

		HPRS Coverage Primary	HPRS Coverage Secondary
Medical/Prescription:	☐	☐	☐
Dental:	☐		
Vision:	☐		

B.) Has this child used a tobacco product 4 or more times per week over the past 6 months? ☐ Yes ☐ No

C.) Is this child eligible for Medicare? *(If yes, please include a copy of Medicare card)* ☐ Yes ☐ No

D.) Is this child a disabled dependent? ☐ Yes ☐ No

If yes, have they applied for Medicare? ☐ Yes ☐ No

E.) Relationship to member: ☐ Natural Child ☐ Adopted Child ☐ Guardianship ☐ Step-Child

Dependent Child #2

Last Name | First Name | Middle Initial

SSN | DOB | Gender: ☐ Male ☐ Female

If age 18 or older, does this child have access to health care through any of the following?

☐ Employment ☐ Spouse ☐ Biological or Step-Parent ☐ Military ☐ College/University

If any of the above are checked STOP HERE – this child is not eligible for HPRS coverage.

A.) Election of Coverage – *Complete for New or Continued Coverage*

		HPRS Coverage Primary	HPRS Coverage Secondary
Medical/Prescription:	☐	☐	☐
Dental:	☐		
Vision:	☐		

B.) Has this child used a tobacco product 4 or more times per week over the past 6 months? ☐ Yes ☐ No

C.) Is this child eligible for Medicare? *(If yes, please include a copy of Medicare card)* ☐ Yes ☐ No

D.) Is this child a disabled dependent? ☐ Yes ☐ No

If yes, have they applied for Medicare? ☐ Yes ☐ No

E.) Relationship to member: ☐ Natural Child ☐ Adopted Child ☐ Guardianship ☐ Step-Child

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Dependent Child #3

Last Name | First Name | Middle Initial

SSN | DOB | Gender: ☐ Male ☐ Female

If age 18 or older, does this child have access to health care through any of the following?

☐ Employment ☐ Spouse ☐ Biological or Step-Parent ☐ Military ☐ College/University

If any of the above are checked STOP HERE – this child is not eligible for HPRS coverage.

A.) Election of Coverage – *Complete for New or Continued Coverage*

		HPRS Coverage Primary	HPRS Coverage Secondary
Medical/Prescription:	☐	☐	☐
Dental:	☐		
Vision:	☐		

B.) Has this child used a tobacco product 4 or more times per week over the past 6 months? ☐ Yes ☐ No

C.) Is this child eligible for Medicare? *(If yes, please include a copy of Medicare card)* ☐ Yes ☐ No

D.) Is this child a disabled dependent? ☐ Yes ☐ No

If yes, have they applied for Medicare? ☐ Yes ☐ No

E.) Relationship to member: ☐ Natural Child ☐ Adopted Child ☐ Guardianship ☐ Step-Child

Section 4 – Signature & 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 health care vendors for the purpose of evaluating and administering claims, including sharing the health information of myself and my dependents. I agree that any premiums for health care coverage will be deducted from my monthly pension payment. I authorize my employer to provide any information necessary to verify my employment status and eligibility for health care coverage.

I understand HPRS currently provides health care coverage for its benefit recipients and their eligible dependents. I further understand health care is not a statutorily mandated benefit. HPRS will provide access to health care coverage to benefit recipients and eligible dependents as HPRS resources permit.

I understand I must notify HPRS within sixty (60) days of changes in my health care status including, but not limited to, divorce, marriage, death, birth, adoption, change in employment status, or if access is gained to medical care through another employer.

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:

2022 Health Care Premiums / Plan Co-Pays

Medical / Prescription (Medical Mutual of Ohio / Express Scripts)

Premium amount changes take effect the month following your birthday.

Retiree or Surviving Spouse Age	Monthly Premium
60 +	$175
56 – 59	$248
52 – 55	$484
< 52	$760

Spouse Age	Monthly Premium
60 +	$235
56 – 59	$309
52 – 55	$545
< 52	$820

The chart above represents premiums for HPRS health care coverage whether HPRS is primary or secondary.

	Monthly Premium
Dependent* or Surviving Children	$152 each
Tobacco Surcharge	$50 each user

* Dependent children 18 and over must take coverage through employment, parent or stepparent employment, spouse employment, military service or a college or university if it is available.

Disability Retirees: In-the-line-of-duty are charged at the 60+ rate. Not-in-the-line-of-duty (off-duty) are charged at the rate based on actual age. Once a retirant / spouse turns 52, 56 and 60, the lower premiums become effective.

Dental & Vision

	Monthly Retiree Premium	Monthly Spouse Premium	Monthly Dependent Child Premium*	Monthly Surviving Spouse Premium	Monthly Surviving Children Premium
Dental	$5	$20	$20	$5	$5
Vision	$5	$5	$5	$5	$5

*A single Dental & Vision premium provides coverage for all dependent children regardless of number.

Coverage Overview / Co-Pay Information

Medical	Non-Medicare (Medical Mutual of Ohio)
General	$20
Specialist	$45*;20% after deductible
Chiropractor	20% after deductible
Emergency Room	$200
Urgent Care	$60
Deductible (per person)	$1,500
Out of Pocket Maximum (per person)	$4,000

*$45 copay at time of service; patient responsible for 100% until deductible is met.

Prescription Drug	Retail (up to 34-day supply)	Home Delivery (90-day supply)
Generic	$15	$30
Brand / Formulary	$30	$60
Brand / Non-Formulary	Not covered	Not covered