

ECTOR COUNTY
 HEALTH INSURANCE
 1010 E. 8TH STREET ROOM 630
 ODESSA, TX 79761
 432-498-4011 Phone 432-498-4097 Fax



HEALTH BENEFITS ENROLLMENT FORM
 PLEASE PRINT

New Enrollment Change

EMPLOYEE NAME			DATE OF BIRTH	DATE OF HIRE (FULL TIME)
LAST	FIRST	MIDDLE INITIAL		
ADDRESS			EFFECTIVE DATE:	
CITY/STATE/ZIP (432) PHONE#			SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> _____
SOCIAL SECURITY NO. (THIS IS YOUR POLICY NO.)	DEPARTMENT	JOB TITLE:	LOCATION:	

YOU ARE : (CHOOSE ONE) ACTIVE RETIRED ECAD

COVERAGE SELECTION: Below is the section to be completed for medical coverage. There will be a premium for the "Self Only" and the "Dependent Coverage".

() SELF ONLY	() SELF & SPOUSE	() SELF & CHILD(REN)	() SELF & FAMILY
<p>Medical Coverage Waiver: I have been given an opportunity to enroll myself and my dependents for medical coverage provided by Ector County's Insurance Benefit Plan and decline such coverage as indicated below: RETIREES: Coverage must be elected at the time of retirement for self and eligible dependents. If Retiree declines Personal and/or Dependent coverage at the time of retirement or cancels enrollment at any time, the retiree will not be allowed to re-enroll self or dependents at a later date.</p> <p style="text-align: center;">() I decline medical coverage for myself and my dependents. (OPT-OUT)</p>			

NOTE: If you do not elect to participate when initially eligible and desire to participate at a later date, you will be required to provide evidence of insurability satisfactory to Ector County. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

DEPENDENT CHILDREN: Once a covered dependent child turns 19 years of age, proof of full-time student status (12 hours or more) needs to be submitted every spring and fall semesters.

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SEX	SOCIAL SECURITY #
SPOUSE					
DEPENDENT 2					
DEPENDENT 3					
DEPENDENT 4					
DEPENDENT 5					
DEPENDENT 6					
DEPENDENT 7					
DEPENDENT 8					
DEPENDENT 9					

ACTIVE EMPLOYEE: I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS EVERY 1ST AND 15TH OF THE MONTH FROM MY PAYROLL CHECK FOR HEALTH INSURANCE PREMIUMS. FOR THOSE COVERAGES I HAVE DECLINED; I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, EVIDENCE OF INSURABILITY WILL BE REQUIRED.

EMPLOYEE SIGNATURE _____ DATE ____/____/____