Northeast Ohio Regional Sewer District

Medical Mutual Employee Enrollment / Change Form

New Hire Date:	Change Effective Date:		
Group #:	Section #:	Level of Benefits: (Please circle) Employee Only Employee + 1 Employee + Family	
Changes: (Please circle) Add dependents due to: Marriage Birth Adoption Drop dependents due to: Divorce Death Other:			

Last Name	First Name	M Initial	
Street Address	City	State	Zip

Coverage Desired: (Please Circle)	
PPO (250 deductible)	PPO2 (1,000 deductible)

Dependent Information:					
Relationship:	Birthdate:	Sex:	Last Name (Only if Different):	First Name:	Social Security #:

*Legal documentation (birth certificate/marriage license) must be submitted with this form to be eligible for enrollment

I hereby request enrollment in the coverage indicated on this enrollment form. I authorize payroll deductions and remittance of any required contribution for my coverage to the sponsor of my group health plan. I have read all of the statements contained in this enrollment form and declare by signing this enrollment form that I am an active, eligible, full-time employee or member of the group and that the information I have provided is true and complete to the best of my knowledge.

_____ _____

Employee Signature Date