GENESEE COUNTY / GENESEE COMMUNITY COLLEGE

MEDICAL ENROLLMENT/CHANGE FORM

New Application _____ **MEDICAL** _____ Indicate Single (S), 2 Person (2P) or Family (F)
Change _____

HEALTH & WELLNESS	☐
PARTNERSHIP PLUS	☐
TRADITIONAL	☐

Reason for Change _____
_____

Employee Name: _____

Department: _____

Employee Signature: _____

Date: _____

Genesee County Self Funded Health Plan

Enrollment Acknowledgement

I hereby certify that the dependent information listed on the Genesee County Self-Funded Health Plan Enrollment/Change Form is true and accurate. I understand that documentation (marriage license, birth certificate) will be requested to verify accuracy of these eligible dependents under the terms of benefit plans offered through Genesee County.

A failure to produce documentation upon request will result in a loss of coverage for those dependents without documentation and the potential of discipline, up to and including termination of employment, for an employee found guilty of fraud.

I further wish to make the benefit choices indicated on this form. I understand that my benefits will be in effect for 2023 unless I change due to a qualified change in status. I authorize Genesee Community College to deduct any money from my paycheck to cover the cost of my Health Plan elections. I also understand that I will be billed for my portion of the costs that would otherwise be deducted from my paycheck should I not receive a paycheck.

Signature of Employee: _____ Date: _____