COSA Benefits Program Forms

The book marked forms can be printed individually by clicking on File/Print… and indicating in the print window the proper Print Range (i.e. “Page From: 8 to 9”).

CITY OF SAN ANTONIO

2004 Benefits Enrollment Form
Fire and Police Enrollment

Name: _____
(Last, First, Middle Initial)

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Social Security No: _____

Date of Birth: _____ Hire Date: _____

In case of emergency contact:

Name: _____

Phone: _____

Relationship: _____

SECTION 2. Complete categories I thru IV. If you choose an HMO plan, attach HMO enrollment form.

FOR OFFICE USE ONLY

Scan

Audit

Process

BENI

BPI

Pend

Other

I. UNIFORM STATUS

- ☐ 1 Fire
- ☐ 2 Police

II. MARITAL STATUS

- ☐ 1 Single
- ☐ 2 Married
- ☐ 3 Divorced

III. COVERAGE LEVEL

- ☐ 1 Employee Only
- ☐ 2 Employee + 1 Dependent
- ☐ 3 Employee + 2 or more

IV. MEDICAL

- ☐ 1 F & P CitiMed
- ☐ 2 Flex Program (call 207-8705)

- CONTINUED ON BACK -

COSA FORM CFX04E

2004 Benefits Enrollment Form

SECTION 3. Enter all dependent information below.

"1" For Spouse
"2" For Dependent Daughter
"3" For Dependent Son
"8" For Common Law Spouse or Legal Guardian of Child (attach legal documentation)

	NAME	BIRTH DATE	RELATION CODE	SOCIAL SECURITY NUMBER
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

If spouse is employed by the City or any other employer, please write the name of the employer and phone number below.

Employer: _____ Phone Number: _____

SECTION 4. Read carefully, sign, date, and return the form to your department's payroll clerk.

I have read the enrollment booklet explaining the City of San Antonio Benefits Program. I hereby make my election of benefits for 2004 and understand that my election cannot be changed once this form is received by the Employee Benefits Office. I further understand that I can only make changes in dependent coverage (i.e. newborn, adoption, marriage, divorce, etc.) with legal documentation. This change can only be done in person at the Employee Benefits office and only within 31 calendar days of a change in family status. I authorize payroll deductions that may result from my elections.

_____ _____

Employee Signature Date

COSA FORM CFX04F

CLAIM FORM

City of San Antonio Employee Benefit Program
Statement of Medical Claims

PARTICIPANT'S STATEMENT (COMPLETE FOR ALL CLAIMS)

Employee's Name (Last, First, Middle)	Employee Social Security #	Employee Birth Date	Claim is for: ☐Self ☐Dependent
Employee's Address (City, State & Zip)		Phone Number	☐Male ☐Single ☐Female ☐Married

☐Claim is for an illness ☐Claim is for an accident	For accident claims the following information *MUST* be provided _____ Date and time of the Accident. How accident happened? Where the accident happened	Is accident related to: Job ☐Yes ☐No Auto ☐Yes ☐No

TO BE COMPLETED IF CLAIM IS FOR DEPENDENT

Name	Date Of Birth	Sex	Relationship	Is Spouse employed? ☐Yes ☐No
☐ Unmarried child (Birth-19 years old) ☐ Unmarried Student Student attending (name of High School, College or University)	Is your Spouse covered for health insurance with their employer? ☐Yes ☐No If yes, full name of health plan, phone number and policy number:			

OTHER INSURANCE INFORMATION

Is there any other insurance coverage available from any other source? ☐Yes ☐No If yes, full name of health plan or insurance carrier, full address and policy number: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer or provider of medical services to release all information to Employee Benefit Administrators, Inc. or their authorized representative, with respect to myself or my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I certify that the above information given by me in support of this claim is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Employee signature _____ Claimant signature _____ Date _____

AUTHORIZATION TO RELEASE BENEFITS TO PROVIDER

I hereby authorize Employee Benefit Administrators, Inc. to release payment of benefits to the physician, supplier, or medical facility for covered services received.

Employee signature _____ Spouse signature _____ Date _____

HOW TO FILE A CLAIM

Submitting Bills

All bills MUST be itemized and include the following:

(1) Employee's name, social security number and the name of the Claimant
(2) Name, address, telephone number and TIN# of the Provider
(3) Date of service, procedure provided, diagnosis for any claims related to an illness or injury

PLEASE:

(1) Do not send cancelled checks or receipts of payment, they *WILL NOT* be accepted
(2) Do not submit bills prepared by you. The actual provider's bill will be needed.

WHERE TO FILE A CLAIM

All Claims Are To Be Mailed To:
City of San Antonio
EBA/USC
P. O. Box 100990
San Antonio, TX 78201-8990
Electronic Billing to: THIN#-USC11
Visit USC website to locate your Doctor: www.USCHealth.com

All Questions Regarding Claims/Benefits

Please call: EBA, Inc.
(210) 253-2002
(800) 478-3845
(210) 738-1448 Fax

UNIFORM EMPLOYEES

Enrollment Group Life Insurance

Aetna Life Insurance Company
Group Insurance
151 Farmington Avenue
Hartford, CT 06156-7350

Employee Hire Date

Employee Social Security Number

Employer Name	City, State	Control Number	Sex
City of San Antonio	San Antonio, Texas	# 701577	☐ Male ☐ Female
Employee Name (First,Middle Initial, Last)	Birthdate (MM-DD-YY)	Marital Status	
		☐ Married	☐ Single ☐ Other

Employee Base Salary	Telephone Numbers
$ _____	Home ( ) _____ - _____
	Work ( ) _____ - _____

Beneficiary Information
Beneficiary Name (First,Middle Initial,Last)

Primary	Relationship	Contingent	Relationship
1		1	
SSN		SSN	
2		2	
SSN		SSN	

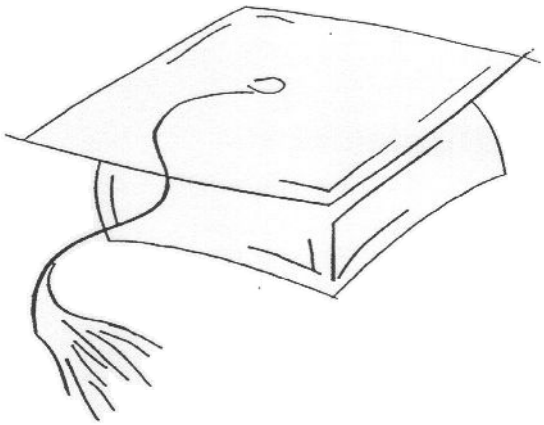
I certify that all of the information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement materials provided to me and the certificate issued to me. I understand that the effective date of insurance for myself is subject to my being actively at work on that date and is also subject to the health condition requirements of the Plan. Further, I request my Employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible for and to authorize deductions of the required contributions from my earnings.

_____
Employees or Authorized Person's Signature
(Required)

_____
Date Signed

CITY OF SAN ANTONIO
EMPLOYEE BENEFITS DIVISION
PO BOX 839966
SAN ANTONIO, TEXAS 78283-3966
(210) 207-8705

ENROLLMENT VERIFICATION



School Name: _____
Address: _____
City: _____
State/Zip: _____

Student: _____
Social Security: _____

Dear Registrar:

Please complete this form for the above named student. Your assistance is appreciated

This certifies that: _____ SSN _____
is enrolled at: _____
for quarter or Semester checked:

- Winter ☐
- Spring ☐
- Summer ☐
- Fall ☐

From: ____ / ____ / ____ To: ____ / ____ / ____

Number of Units ☐

Full Time Status Yes ☐ No ☐

Signature _____ Date _____
(Registrar/Authorized Agent) Affix Seal here

For Office Use Only:

dependent of	