



# LEGAL PLAN ENROLLMENT FORM

Enrollment  Change Coverage Level  Date of Family Status Change \_\_\_\_\_ Drop Coverage

Coverage level may only be changed within 31 days of the occurrence of the family status change.

Member Name (First, Middle, Last) \_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Street Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_

Union Name \_\_\_\_\_

Agency Name \_\_\_\_\_

Work Address \_\_\_\_\_

State of Ohio User ID \_\_\_\_\_

Work Phone \_\_\_\_\_ Alternate Phone Number (Not Work) \_\_\_\_\_

## LEVEL OF COVERAGE

SINGLE \$15.90 a month

FAMILY \$18.95 a month

I authorize the State of Ohio to take the premium for the legal service plan coverage I select once a month from my pay. Coverage will begin under the plan July 1, 2017. I understand that my election will remain in force until I change or drop my coverage, and that I may only make changes/drops during open enrollment for the following July 1 coverage effective date. My coverage will also end if I am no longer an eligible UBT member or I leave State employment, once payroll deductions stop.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

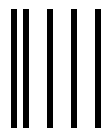
**AFTER SIGNING AND DATING THE FORM, MAIL IT TO HYATT.**

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Group legal service plans are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio.

To mail, fold this end down first.

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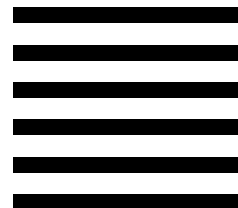


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HYATT LEGAL PLANS INC  
SUITE 800  
1111 SUPERIOR AVE E  
CLEVELAND OH 44114-9584



FOLD HERE

Second, fold this end up, and place tape on edge, in center.  
Bottom fold should be smooth and not taped.