

DESIGNATION FORM

I hereby designate _____
(third party)

to receive all notices regarding my health insurance with Onondaga County that would otherwise be sent to be by Onondaga County or their designee.

Address of third party:

Signature of Insured

Name of Insured

Social Security Number of Insured

Date

I hereby accept the designation made by the insured for me to receive all notices from Onondaga County regarding his/her health insurance. I understand that this designation imposes upon me no liability for services provided to the insured

Signature of Designee

Date

NOTE: TO BE VALID, THIS FORM MUST BE COMPLETED AND SIGNED BY BOTH PARTIES AND DELIVERED TO ONONDAGA COUNTY, EMPLOYEE BENEFITS, 421 MONTGOMERY STREET, 15TH FLOOR, SYRACUSE, NY 13202