HealthPlans, Inc.

Member Enrollment / Change Form

Employer Name: Town of Webster **Group Number: BP3**

To Be Completed by Employer *(this section must be completed prior to submitting to Health Plans)*

Hire Date:_____ Effective Date:_____ Termination Date:_____ Change Effective Date:_____

Please indicate: ☐ Active ☐ COBRA Department/Division/Location *(if applicable)*: _____

Please indicate reason(s) for change or enrollment:

☐ New Employee ☐ Open Enrollment ☐ Change of Address ☐ Special Enrollment

☐ Add Dependent Coverage – Reason: _____ if requesting coverage for employee's spouse: _____ *date of marriage*

☐ Terminate Dependent Coverage – Reason: _____

☐ Change of Status – Reason: _____ ☐ Other: _____

To Be Completed by Employee

Employee Last Name	*First Name*	*MI*	*Social Security Number*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*

Gender	*Marital Status*	*Email Address*	*Primary Phone*

Health Coverage Election

Medical Plan Option (select one): ☐ Network Tiering Plan ☐ PPO Plan

Employee Only	*or*	Employee + : Spouse/Partner	Child(ren)	Family	Ex-Spouse
☐ Medical		☐ Medical	☐ Medical	☐ Medical	☐ Medical

Dependents

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*	*Dependent Social Security Number (REQUIRED)*	*Add Dependent*	*Drop Dependent*
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

Are you or any of your dependents covered by another ***medical*** plan? ☐ Yes ☐ No ☐ Self ☐ Spouse/Partner ☐ Child(ren) ☐ Ex-Spouse

If yes, Medical Policy No. & Insurance Co.: _____ Policyholder: _____

Name/Address of Policyholder's Employer: _____

Election of Coverage

******Important****** **To accept coverage, select YES, sign, and date this section.**

☐ **YES** • *I wish to elect coverage under my employer's benefit plan for the coverage indicated above. I understand that my application will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives. A photocopy shall be as valid as the original. • I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage.*

Signature: _____ _____

Signature of Employee *Date Signed*

Waiver of Coverage

☐ **NO** • *If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.*

Signature: _____ _____

Signature of Employee *Date Signed*

***** PLEASE RETURN COMPLETED FORM TO YOUR HUMAN RESOURCES DEPARTMENT *****

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