

Employer Name: _____

Group Number: _____

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

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 (if applicable): _____

Employee Only Medical or Employee + : Spouse Medical Child(ren) Medical Family Medical

Dependents

Last Name	First Name	MI	Gender	Date of Birth	Relationship	Dependent Social Security Number (REQUIRED)	Add Dependent	Drop Dependent
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

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

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

Name/Address of Spouse's/Partner's/Ex-Spouse'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 *****
 Health Plans, Inc. — Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575