



# Member Enrollment / Change Form

Employer Name: **Town of Douglas**

Group Number: **BP2**

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):  PPO Plan - QHDP  Network Plan (EPO) - QHDP

Employee Only  Medical Employee + Family  Medical Ex-Spouse  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)  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 TREASURER'S OFFICE, DOUGLAS TOWN HALL, 29 DEPOT ST., DOUGLAS, MA 01516 \*\*\*

Health Plans, Inc. - Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575

