



Member Enrollment/Change Form

Employer Name: _____

Group Number: _____

To Be Completed by Employer (this section must be completed prior to submitting to HPI)

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 Address Change 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): _____

Dental Plan Option (if applicable): _____

Employee Only Employee + Spouse/Partner Employee + Child(ren) Employee + Family Employee + Ex-Spouse

Dependents

Last Name	First Name	MI	Gender	Date of Birth	Relationship to Employee	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"/>

Please indicate if you or any of your dependents are covered by another **medical** plan: _____

Please indicate if you or any of your dependents are covered by another **dental** plan: _____

(if applicable):

Medical Policy# and Insurance Co.: _____ Policyholder's Name: _____

Dental Policy# and Insurance Co.: _____ Policyholder's Employer: _____

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 and/or dental records to Health Plans, Inc. (HPI) 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. (HPI) — Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575