



Health New England Enrollment Form

Please check reason for completing this form

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Reinstatement Effective Date: / /	If this is a Change, please indicate type of Change and reason below.				
<input type="checkbox"/> Cancel Employee <input type="checkbox"/> Termination <input type="checkbox"/> Other – Reason:	<input type="checkbox"/> Add Dependents <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Other – Reason:	<input type="checkbox"/> Cancel Dependent(s) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Change in Student Status <input type="checkbox"/> Other – Reason:	<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<input type="checkbox"/> Transfer to COBRA Qualifying Event <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Dep. Status Change <input type="checkbox"/> Other – Reason:	

Employer Information – To Be Completed By Employer

Employer Name: Town of Greenfield	Employee's Date of Hire:	Division:	Class:	Location:	Salary:	Scheduled Weekly Hrs:
Health New England 112853		Job Title			Department	

Employee Information

Employee Name: Last First M.I.	Social Security #	Home Phone:	Work Phone:
Address: Street Apt. City State Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Gender:	

Medical Selection Or Waiver – Health New England

<input type="checkbox"/> WAIVE COVERAGE	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	<input type="checkbox"/> Employee <input type="checkbox"/> Two-Person <input type="checkbox"/> Family
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Employee & Dependent Information (Identify yourself and any dependents you want covered, dropped or changed for Medical)

Name (Last, First, MI)	Drop Add	Sex	FT Student	Birth Date	Soc. Sec. #	Primary Care Doctor	Provider ID#	Patient <input type="checkbox"/> Existing <input type="checkbox"/> New
Self	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Existing <input type="checkbox"/> New
Spouse	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Existing <input type="checkbox"/> New
Child	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Existing <input type="checkbox"/> New
Child	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Existing <input type="checkbox"/> New
Child	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> Existing <input type="checkbox"/> New

Other Insurance Coverage

Are you or your dependents covered by other group medical coverage? Yes No If yes, please complete the following information.

Name of Person	Employer Name, Medicare, Medicaid	Insurance Co. Name, Medicare, Medicaid	Type of Coverage	Policy Number
			<input type="checkbox"/> Medical	

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

1) Apply for the benefits designated for which I am eligible under my employer's plan with Health New England, Guardian and my employer's Section 125 Cafeteria Plan. 2) Represent that all of the information on this Enrollment/Change Form is complete, correct and true. 3) Agree that a photocopy of this Enrollment/Change Form shall be considered to be valid and effective as the original. 4) Understand that if I have waived enrollment in any benefits for which I am eligible, and later wish to apply for the benefits I have waived, my application for enrollment in those benefits may be declined, or I may have to furnish at my own expense, evidence of insurability which is satisfactory to the Insurance Companies and my Employer. 5) Authorize any required deductions from my earnings. 6) Understand that I must meet all the eligibility requirements of my employer's plans to remain insured.

Employee Signature: _____ Date: _____

Authorized Employer Signature: _____ Date: _____

Internal Use Only

Census <input type="checkbox"/> _____	Sent HNE <input type="checkbox"/> _____	Payroll <input type="checkbox"/> _____
Town Ret. <input type="checkbox"/> _____	Ret. Teacher <input type="checkbox"/> _____	United American <input type="checkbox"/> _____
WEBCOBRA <input type="checkbox"/> _____		