



Health New England Enrollment Form

7/1/2020- 6/30/2020 Plan year

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"/> Other - Reason:	<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change

Employer Information - To Be Completed By Employer

Employer Name: City of Greenfield	Employee's Date of Hire:	Division: 0030-CITY HMO 0032-FHETC HMO 0023-CITY PPO 0025- FHETC PPO 0050-CITY HMO HDHP 0054-FHETC HMO HDHP 0051-CITY PPO HDHP 0055-FHETC PPO HDHP 0036-SCHOOL HMO 0033-GCET HMO 0037-SCHOOL PPO 0026-GCET PPO 0042-SCHOOL HMO HDHP 0060-GCET HMO HDHP 0043-SCHOOL PPO HDHP 0061-GCET PPO HDHP	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

Medical Coverage

<input type="checkbox"/> WAIVE COVERAGE	<input type="checkbox"/> HMO <input type="checkbox"/> HMO HDHP (High ded. health plan)	<input type="checkbox"/> PPO <input type="checkbox"/> PPO HDHP (High ded. health plan)	<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
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"/>	COBRA spreadsheet <input type="checkbox"/>
Boston Mutual <input type="checkbox"/>	Guardian <input type="checkbox"/>	Town Ret. <input type="checkbox"/>	United American <input type="checkbox"/>
FSA <input type="checkbox"/>	WEBCOBRA <input type="checkbox"/>	Ret. Teacher <input type="checkbox"/>	