Health New England Enrollment Form

Please check reason for completing this form

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

Employer Information – To Be Completed By Employer

Employer Name: **Town of Greenfield**	Employee's Date of Hire:	Division: **0030**-HMO **0023**-PPO **0032**-FHETC HMO **0033**-GCET HMO OTHER: **0025**-FHETC PPO **0026**-GCET PPO	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: ☐ Single ☐ Married ☐ Divorced ☐Widowed	Gender:

Medical Selection Or Waiver – Health New England ***Medical Coverage***

☐ **WAIVE COVERAGE**	☐ **HMO**	☐ **PPO**	☐ **Employee** ☐ **Two-Person** ☐ **Family**

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	☐ Drop ☐ Add	☐ M ☐ F						☐ Existing ☐ New
Spouse	☐ Drop ☐ Add	☐ M ☐ F						☐ Existing ☐ New
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N					☐ Existing ☐ New
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N					☐ Existing ☐ New
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N					☐ Existing ☐ 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
			☐ 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	❒ _____	Sent HNE	❒ _____	Payroll	❒ _____
Boston Mutual	❒ _____	Guardian	❒ _____	Town Ret.	❒ _____
FSA	❒ _____	WEBCOBRA	❒ _____	Ret. Teacher	❒ _____
COBRA spreadsheet	❒ _____	United American	❒ _____		