# Member Enrollment/Change Form

**Employer Name:** Town of Oxford **Group Number:** BP4

**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):*** _____

☐ **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* |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ | ☐ |
| | | | | | | | ☐ | ☐ |
| | | | | | | | ☐ | ☐ |
| | | | | | | | ☐ | ☐ |
| | | | | | | | ☐ | ☐ |

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

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

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. (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