

**Employer Name: Dudley-Charlton Regional School District**
**Group Number: BP1**
**To Be Completed by Employer (this section must be completed prior to submitting to Health Plans)**

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  Change of Address  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	

<b>Health Coverage Election</b>		Medical Plan Option (select one): <input type="checkbox"/> Network Plan <input type="checkbox"/> PPO Plan <input type="checkbox"/> \$1,000 Network Plan				
Employee Only	or	Employee + :	Spouse/Partner	Child(ren)	Family	Ex-Spouse
<input type="checkbox"/> Medical		<input type="checkbox"/> Medical	<input type="checkbox"/> Medical	<input type="checkbox"/> Medical	<input type="checkbox"/> Medical	<input type="checkbox"/> Medical

**Dependents**

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

 Are you or any of your dependents covered by another **medical** plan?  Yes  No  Self  Spouse/Partner  Child(ren)  Ex-Spouse

If yes, Medical Policy No. &amp; Insurance Co.: \_\_\_\_\_ Policyholder: \_\_\_\_\_

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. 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 \*\*\***