COMMUNITY COLLEGE OF PHILADELPHIA

Benefit Enrollment/Change Form

Effective Date: _____
(HR Department use only)

Employee must complete in full (please print). Return form to the Office of Human Resources.

Deadlines:

- **Initial eligibility into a benefits plan expires 30 days after the date of hire. (Classified Union – 90 days)**
- **Changes in Family Status eligibility expires 30 days after life event (e.g. marriage, divorce, birth, etc.)**
- **Annual Open Enrollment is announced each year – typically runs from the last week in August through the end of the second week in September.**

EMPLOYEE INFORMATION: ☐New Enrollment ☐Open Enrollment Change ☐Life Status Change ☐Name Change ☐Address Change ☐ Termination

Employee's Name:		
Home Address:	City	State/ZIP
Home Phone:	Work Phone:	
Date of Birth:	Date of Hire:	Gender: ☐ Male ☐Female
SSN:	Banner #:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Classification:
☐ Faculty-AY ☐ Visiting Lecturer ☐ FT Administrator ☐ FT Confidential ☐ Grant Administrator
☐ Faculty-CY ☐ Part Time Faculty ☐ FT Classified ☐ PT Classified ☐ Temp Administrator

Employment Status: ☐ Part-Time ☐ Full-Time ☐ COBRA ☐ LTD ☐ Early Retiree ☐ WC

Life Event Change:	**Change Reason**
☐ Add a family member ☐ Remove a family member **Proof of Relationship:** ☐ Marriage Certificate - S ☐ Birth Certificate(s) - C ☐ Declaration/Affidavit – DP	☐ Marriage/Domestic partner ☐ Divorce ☐ Birth/Adoption ☐ Death ☐ Dependent Loss of Coverage ☐ Over-age Dependent Child ☐ Other – Describe

BENEFIT CHOICES:

Medical Insurance: Check one	**Prescription Coverage:** Check one	**Dental Insurance:** Check one
☐ NO COVERAGE ☐ Keystone POS PA ☐ Personal Choice	☐ NO COVERAGE ☐ CVS Caremark	☐ NO COVERAGE ☐ Delta Care (HMO) ☐ Delta Premier ☐ United Concordia Plus (HMO)
Subscriber/Dependent Coverage: ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family	**Subscriber/Dependent Coverage:** ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family	**Subscriber/Dependent Coverage:** ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Membership Information: *Please provide requested information for self and each dependent you wish to cover. Check the applicable box to indicate if a dependent is to be covered under each benefit plan. Select a Primary Care Physician and/or Dentist for each person, if you are enrolling in Keystone, DeltaCare or United Concordia plan. The College reserves the right to verify eligibility of all dependents.*

Full Name Last, First, MI	**Social Security #**	**Sex (M/F)**	**DOB M/D/Y**	**Relation Code ***	**Check for Each Person**	**National Provider Identifier (NPI)** Available on Blue Cross website
(Employee) , ,	- -				☐ Medical ☐ Dental	
(Spouse) , ,	- -				☐ Medical ☐ Dental	
(Child) , ,	- -				☐ Medical ☐ Dental	
(Child) , ,	- -				☐ Medical ☐ Dental	
(Child) , ,	- -				☐ Medical ☐ Dental	
(Child) , ,	- -				☐ Medical ☐ Dental	

***E = Employee S = Spouse C = Child F = Full-Time Student/Dependent D = Disabled DP = Domestic Partner**

FOR HMO:

Primary Physician	Are you a current patient of this Physician? ☐ Yes ☐ No
Primary Dentist	Are you a current patient of this Dentist? ☐ Yes ☐ No

Coordination of Benefits: Complete this section if you and /or your dependents are covered by any other Medical/Dental Insurance.

Is your spouse employed? ☐Yes ☐ No If yes, please indicate name and address of employer. Company Name:	Is your spouse covered by any other Health or Dental Insurance? ☐Yes ☐No If other insurance, please indicate name and policy #. Name: Policy #
Address: _____ City: State: Zip Code:	Who is covered by this policy? ☐ You ☐ You & Spouse ☐ Spouse ☐ Children ☐ Family

Declaration

I elect coverage under the plans specified on this application for the persons listed and agree to abide by the conditions of the agreement. If applicable, I agree to pay any required premiums for the plans selected. I and my listed eligible dependent(s) authorize any hospital, physician or other healthcare provider to furnish all Insurance providers, its assignee or designee, with such medical information about the applicant and dependent(s) listed on the applications as may be required for claim payment, utilization review, quality assurance or in fulfillment of obligations imposed by applicable state or federal law. I understand that my coverage(s) will become effective upon the approval of my application. I understand and agree that; (1) the agreement may contain waiting periods; (2) Coverage is subject to the terms and conditions of the applicable insurance agreement. (3) the agreement(s) shall be binding on all the Insurance providers as applicable, whose plans are contained herein only if all my statements are complete and true.

Notice Regarding Fraudulent Information:

Any person who knowingly and with intent to defraud any insurance company or other person(s) files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any facts material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's Agreement

I request to arrange for the above coverage and direct the College to deduct any required contributions from my regular pay. I understand my election will become irrevocable for the entire plan year unless there is a change in my family status or during open enrollment.

Employee's signature:_____ Date: _____

Employer's signature:_____ Date: _____