

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: <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN:	Banner #:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Employment Classification:		
<input type="checkbox"/> Faculty-AY <input type="checkbox"/> Visiting Lecturer <input type="checkbox"/> FT Administrator <input type="checkbox"/> FT Confidential <input type="checkbox"/> Grant Administrator <input type="checkbox"/> Faculty-CY <input type="checkbox"/> Part Time Faculty <input type="checkbox"/> FT Classified <input type="checkbox"/> PT Classified <input type="checkbox"/> Temp Administrator		
Employment Status: <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> COBRA <input type="checkbox"/> LTD <input type="checkbox"/> Early Retiree <input type="checkbox"/> WC		
Life Event Change:		Change Reason
<input type="checkbox"/> Add a family member <input type="checkbox"/> Remove a family member <u>Proof of Relationship:</u> <input type="checkbox"/> Marriage Certificate - S <input type="checkbox"/> Birth Certificate(s) - C <input type="checkbox"/> Declaration/Affidavit – DP		<input type="checkbox"/> Marriage/Domestic partner <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Over-age Dependent Child <input type="checkbox"/> Other – Describe

BENEFIT CHOICES:

Medical Insurance: Check one <input type="checkbox"/> NO COVERAGE <input type="checkbox"/> Keystone POS PA <input type="checkbox"/> Personal Choice	Prescription Coverage: Check one <input type="checkbox"/> NO COVERAGE <input type="checkbox"/> CVS Caremark	Dental Insurance: Check one <input type="checkbox"/> NO COVERAGE <input type="checkbox"/> Delta Care (HMO) <input type="checkbox"/> Delta Premier <input type="checkbox"/> United Concordia Plus (HMO)
Subscriber/Dependent Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family	Subscriber/Dependent Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family	Subscriber/Dependent Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> 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	Relati on Code *	Check for Each Person	National Provider Identifier (NPI) Available on Blue Cross website
(Employee) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
(Spouse) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
(Child) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
(Child) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
(Child) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
(Child) , ,	- -				<input type="checkbox"/> Medical <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Dentist	Are you a current patient of this Dentist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate name and address of employer. Company Name:	Is your spouse covered by any other Health or Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If other insurance, please indicate name and policy #. Name: Policy #
Address: _____ City: State: Zip Code:	Who is covered by this policy? <input type="checkbox"/> You <input type="checkbox"/> You & Spouse <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> 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: _____