RELEASE FORM FOR PARTICIPATION IN CCP MEDICAL PLANS AS ADMINISTERED BY BCI

NAME: _____
(Please Print)

SOCIAL SECURITY NUMBER: _____

I have read and understood the Participation Rules for the plans noted above, and agree to make the required payments for the insurance plans in which I enroll.

I understand that my coverage, as an employee of Community College of Philadelphia, under health plans obtained through the College and administered by Brokerage Concepts d/b/a HealthNow, is independent of whether I work during a given semester. My coverage remains in force if I am not working, unless I cancel it.

I understand that if, for any reason, I wish to discontinue benefits I must notify Brokerage Concepts d/b/a HealthNow **in writing** prior to the last date I wish to be covered.

I understand that if I become eligible for fully-paid benefits through the College (e.g. as a Visiting Lecturer or permanent full-time employee or spouse thereof) I must terminate my current benefits by notifying Brokerage Concepts d/b/a HealthNow in writing as soon as I enroll in the College plans, but in no case later than the new College-paid insurance goes into effect.

I understand that my failure to notify Brokerage Concepts d/b/a HealthNow in writing, in a timely manner, of any changes in eligibility or decisions to terminate my plans will result in my incurring liability for full premium payments and any administrative or banking fees incurred by Brokerage Concepts d/b/a HealthNow owed to my failure to send them timely notification. Such administrative fees will include a $35 administrative charge, along with any banking fees incurred by Brokerage Concepts d/b/a HealthNow, if I have failed to keep adequate money in my account for a scheduled debit payment.

I understand that new rates go into effect each September 1, and that it is my responsibility to read College materials sent out each year on this topic. These materials will include contact information for Brokerage Concepts d/b/a HealthNow such as mailing address and the name, phone number and e-mail address of Brokerage Concepts d/b/a HealthNow personnel administering the plans. Adjustments will be made each September for the difference between premiums paid and new premium rates due. I understand that it is my responsibility to see that there is enough money in my account to cover these adjustments.

SIGNATURE: _____

DATE: _____

Please keep a copy of this form for your records and return the original to CCP, Attn: Lolita Lukes.