

City of Worcester Insurance Enrollment and Change Form ** NOT FOR BCBS ENROLLMENT OR CHANGES

Employee Information				Social Security #	DOB / /
Last Name:	First Name:	MI		PCP Name:	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	City	State	Zip Code	Check One: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor	Department:
Primary Language:	Race:	Ethnicity:		H Phone:	W Phone:

REASON FOR TRANSACTION:	Adding Coverage:	<input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Qualifying Event (explain) <input type="checkbox"/> Other (explain)			
Effective Date:	Ending Coverage:	<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Change to Other Insurance (name other insurance) <input type="checkbox"/> Other			
Changes to Existing Coverage:	Change to: <input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Change of Health Plan	Addition or Removal of Family Members: <input type="checkbox"/> Dependent <input type="checkbox"/> Spouse		
	<input type="checkbox"/> Remarks		Date of Marriage or Divorce:		

CURRENT Health Plan for Active Employees & Non-Medicare Retirees/Survivors.
Select one of the Health Plans below & Check if it is a Family or Individual Plan

<input type="checkbox"/> Fallon Direct	ID Number:	Group #: (Benefits office use only)	<input type="checkbox"/> Family Plan
<input type="checkbox"/> Fallon Select	ID Number:		<input type="checkbox"/> Individual Plan
<input type="checkbox"/> BCBS Blue Choice	ID Number:		

NEW Health Plan for Active Employees & Non-Medicare Retirees/Survivors
Select one of the Health Plans below & Check if it is a Family or Individual Plan

<input type="checkbox"/> City of Worcester Direct	Group #: (Benefits office use only)	<input type="checkbox"/> Individual Plan	<input type="checkbox"/> Altus High <input type="checkbox"/> Altus Low <input type="checkbox"/> I <input type="checkbox"/> 2 <input type="checkbox"/> Family
<input type="checkbox"/> City of Worcester Advantage Plan		<input type="checkbox"/> Family Plan	<i>(Altus- 2 person plan for retirees only)</i>
<input type="checkbox"/> Fallon Direct			<input type="checkbox"/> United Healthcare Vision <input type="checkbox"/> I <input type="checkbox"/> 2 <input type="checkbox"/> Family
<input type="checkbox"/> Fallon Select			

Dependent Information					
Name of Dependent: (last/first/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.	PCP Selection Ever treated by this Dr.?		
Relation to Insured:	DOB: / /	Primary Language:	Race:	Ethnicity:	
Name of Dependent: (last/first/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.	PCP Selection: Ever treated by this Dr.?		
Relation to Insured:	DOB: / /	Primary Language:	Race:	Ethnicity:	
Name of Dependent: (last/first/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.	PCP Selection: Ever treated by this Dr.?		
Relation to Insured:	DOB: / /	Primary Language:	Race:	Ethnicity:	
Name of Dependent: (last/first/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.	PCP Selection: Ever treated by this Dr.?		
Relation to Insured:	DOB: / /	Primary Language:	Race:	Ethnicity:	

Employee Signature: _____ Date: _____ Employer Signature: _____ Date: _____