



City of Worcester Advantage Insurance Enrollment and Change Form

Check one: Settled Non-Settled New Settled

Employee information: Last name			First name		MI	Social Security #:		DOB: / /	
Address:						PCP name:		DOH: / /	
City:			State:		ZIP Code:		Ever treated by this PCP? Y/N		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Primary language:			Race:		Ethnicity:		Check one: <input type="checkbox"/> Active employee <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor		
Are you covered by Medicare? Y/N	Part A effective:		Part B effective:		Medicare #:		Department:		Phone (H):
							Phone (W):		
Effective date:	<input type="checkbox"/> New hire <input type="checkbox"/> Open enrollment		Change to family: <input type="checkbox"/> Add spouse <input type="checkbox"/> Add dependent		Change to individual: <input type="checkbox"/> Remove dependent(s)		<input type="checkbox"/> Termination of employment <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other		
Remarks:									
Select one of the health plans below and indicate family or individual plan:									
<input type="checkbox"/> City of Worcester Direct			<input type="checkbox"/> Individual Plan			<input type="checkbox"/> Family Plan			(Benefits office use only)
<input type="checkbox"/> City of Worcester Advantage									Group#
<input type="checkbox"/> City of Worcester Advantage QHDP									ID#
Dependent information:									
Spouse/Ex-spouse: (Last/First/MI)				Circle one: M F	Social Security #:		DOB: / /		Are you covered by Medicare? Y/N
							Part A effective:		Part B effective:
PCP name:				Ever treated by this PCP? Y/N		Medicare #:			
Dependent child: (Last/First/MI)				M F	Social Security #:		DOB: / /		PCP:
							Ever treated by this PCP? Y/N		
Dependent child: (Last/First/MI)				M F	Social Security #:		DOB: / /		PCP:
							Ever treated by this PCP? Y/N		
Dependent child: (Last/First/MI)				M F	Social Security #:		DOB: / /		PCP:
							Ever treated by this PCP? Y/N		
Dependent child: (Last/First/MI)				M F	Social Security #:		DOB: / /		PCP:
							Ever treated by this PCP? Y/N		

Employee signature: _____ Date: _____ Employer signature: _____ Date: _____