



# City of Worcester Advantage Insurance Enrollment and Change Form

Check one:     **Settled**                       **Non-Settled**

<b>Employee Information</b>		Last Name	First Name	MI	Social Security #	DOB:
Address					PCP Name:	DOH:
City		State	Zip Code		Ever treated by this PCP?	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):

<b>Effective Date</b>	<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
	<b>Remarks:</b>			

<b>Select one of the Health Plans below &amp; indicate Family or Individual Plan</b>				
<input type="checkbox"/> City of Worcester Direct	<input type="checkbox"/> Individual Plan	<input type="checkbox"/> Family Plan	(Benefits office use only) Group# ID#	
<input type="checkbox"/> City of Worcester Advantage				

<b>Dependent Information</b>				
Spouse/Ex-spouse: (Last/First/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	DOB:   /   /	Are you Covered by Medicare? Y/N
			Part A Effective:	Part B Effective:
PCP Name:	Ever treated by this PCP?		Medicare #:	
Dependent Child: (Last/First/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	DOB:   /   /	PCP?
			Ever treated by this PCP?	
Dependent Child: (Last/First/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	DOB:   /   /	PCP?
			Ever treated by this PCP?	
Dependent Child: (Last/First/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	DOB:   /   /	PCP?
			Ever treated by this PCP?	
Dependent Child: (Last/First/MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	DOB:   /   /	PCP?
			Ever treated by this PCP?	

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_