

# ENROLLMENT/CHANGE FORM

Change  Termination  Disability  Retirement  
Reason for change: \_\_\_\_\_

Effective: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Chg ( )	NAME OF EMPLOYER: CITY OF HIALEAH	DEPARTMENT:	<input type="checkbox"/> UNITED HEATHCARE CHOICE PLUS <input type="checkbox"/> COVENTRY <input type="checkbox"/> HUMANA
Chg ( )	NAME OF EMPLOYEE: Last:	FIRST:	MIDDLE:
Chg ( )	ADDRESS:	Number & Street:	Apt. #:
Chg ( )	City:	State:	Zip: Phone:

<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra	Hire/Rehire Date: / /	Date of Birth: / /	Social Sec. #: - -	<input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> Date: / /
--	---	--------------------------	-----------------------	-----------------------	--

**PLEASE COMPLETE ALL APPLICABLE BENEFIT SELECTIONS**

I am enrolling/enrolled in:	SINGLE	DOUBLE	FAMILY	I want to change to:	SINGLE	DOUBLE	FAMILY
Medical Benefits				Medical Benefits			

Eligible Dependents: Last Name	First Name	Social Security Number	Relationship	Birth Date	Sex	Other Insurance:
Spouse:					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
**Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
**Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
**Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
**Child:					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Relationship examples: spouse, son, daughter, stepchild, adopted child, other (specify).

\*\* Proof of dependent eligibility may be required.

**PRIOR COVERAGE INFORMATION**

You may be eligible for pre-existing condition limitation credit. Please attach a certificate from your prior carrier for pre-existing credit.

Prior Medical insurer \_\_\_\_\_ Effective Date \_\_\_\_\_ Termination date \_\_\_\_\_

Phone Number of Prior Insurer \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy ID Number \_\_\_\_\_

**OTHER INSURANCE**

Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: <input type="checkbox"/> Single <input type="checkbox"/> Family
Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: <input type="checkbox"/> Single <input type="checkbox"/> Family
Employee - Policy Holder's Name:	Insurance Company Name:	Coverage is: <input type="checkbox"/> Single <input type="checkbox"/> Family

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactively termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Benefit Services, Inc. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature of Employee \_\_\_\_\_

Date Signed \_\_\_\_\_

Signature of Employer \_\_\_\_\_

Date Signed \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE COVERAGE**

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document. I understand that by waiving coverage, I am also waiving my right to participate in the City's Group Life Program.

Waiver of Coverage for: \_\_\_\_\_  Medical/Group Life Reason for Waiving: \_\_\_\_\_

Signature of Employee \_\_\_\_\_

Date Signed \_\_\_\_\_

**TO BE COMPLETED BY THE RISK MANAGEMENT DIVISION**

General Employees	Sworn Police	Sworn Firefighters
Carrier	Rate: Bi-Weekly	Rate: Monthly

Comments: \_\_\_\_\_

Notified Payroll \_\_\_\_\_

Notified Retirement \_\_\_\_\_

(mav/United Enrollment.Form.xls)