HealthPlans
A HARVARD PILGRIM COMPANY

Enrollment / Change Form for Iwaki America, Inc.

Group Number: 001N98

To Be Completed by Employer (this section must be completed prior to submitting to Health Plans)

Hire Date ___/___/___ Effective Date ___/___/___ Term Date ___/___/___ Change Eff. Date ___/___/___

Please indicate: ☐ Active ☐ COBRA **Please indicate provider network:** ☐ Harvard Pilgrim ☐ PHCS ☐ First Health

Please indicate reason(s) for change or enrollment:

- ☐ New Hire/Rehire
- ☐ Change of Name and/or Address
- ☐ Change of Status – Reason: ______________
- ☐ Add Dependent Coverage – Reason: ______________
- ☐ Terminate Dependent Coverage – Reason: ______________
- ☐ Other: ______________
- ☐ Open Enrollment
- ☐ Special Enrollment
- ☐ Involuntary Loss of Coverage

(if applying for coverage for your spouse ______________) *date of marriage*

To Be Completed by Employee

Employee Last Name	*First Name:*	*MI*	*Social Security Number*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*	*Home Phone*	*Email Address*

Gender	*Marital Status*
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Were you or your dependents covered under a prior medical plan? ☐ Yes ☐ No *If yes, please include your "Certificate(s) of Prior Coverage"*

Health Coverage Election

Please indicate medical coverage selected: ☐ **Employee Only** ☐ **Employee +1** ☐ **Family**

Dependents

Please check one (if applicable): ☐ **Dependents to be Added** ☐ **Dependents to be Dropped**

Last Name	*First Name*	*M*	*Gende*	*Date of Birth*	*Relationship*	*Dependent Social Security Number* (required)	*Additional Information*

Are you or any of your dependents covered by another *medical* plan? ☐ Yes ☐ No *(if yes):* ☐ Self ☐ Spouse ☐ Children ☐ Ex-Spouse

If yes, Medical Policy No. & Insurance Co.: ______________

Name and address of Spouse's or Ex-Spouse's Employer: ______________

Election of Coverage

IMPORTANT: To accept coverage, select YES, sign and date this section.

☐ **YES** • I wish to elect coverage under my employer's benefit plan for the coverages indicated above. I understand that my application will be subject to the terms of the Plan requirements. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives. A photocopy shall be as valid as the original. • I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage.

Signature: ______________ ______________
Signature of Employee *Date Signed*

Waiver of Coverage

☐ **NO** • If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature: ______________ ______________
Signature of Employee *Date Signed*

*** * * PLEASE RETURN COMPLETED FORM TO HUMAN RESOURCES * * ***

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