VillageofHoffmanEstates

Benefits Enrollment Form - Union Active Employees

Return your completed and signed form to HRM within 30 days of your first day of employment or within 30 days of your qualified status change.

Your Personal Information Enrollment Type:

Name (Last, First, Middle Initial)	Effective Date	Social Security Number
Street Address	City, State, Zip	Primary Phone Number
Email Address:		Birthdate

Changes to Existing Coverage

Add Dependents
Date: _____
☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other:
_____

Cancel Dependents
Date: _____
☐ Divorce
☐ Age Limit
☐ Other: _____

Cancel
Date: _____
☐ Terminate Coverage
☐ Other: _____
_____
_____
_____

Persons to be Enrolled/Dependent Information

Last Name (If different from Employee)	First Name	Social Security No.	Relationship	Gender (M/F)	D.O.B.	Health Plan (y/n)	Dental Plan (y/n)	Vision Plan (y/n)

Health Plan Effective Date: _____

Select one health plan and one coverage level:

☐ PPO1 - ☐ Employee ☐ Family
☐ PPO2 - ☐ Employee ☐ Family
☐ PPO3 - ☐ Employee ☐ Employee+1 ☐ Family
☐ HMO - ☐ Employee ☐ Family
*If choosing HMO – see below for additional information needed
☐ HSA - ☐ Employee ☐ Family

Are you or any dependents covered by Medicare? ☐ Y ☐ N – If yes, see HRM for additional information needed.

Dental Plan Effective Date:_____

Select one health plan and one coverage level:

☐ PPO1 - ☐ Employee ☐ Employee+1 ☐ Family
☐ PPO2 - ☐ Employee ☐ Employee+1 ☐ Family
☐ PPO3 - ☐ Employee ☐ Employee+1 ☐ Family

Vision Plan Effective Date: _____

Select one:

☐ Employee
☐ Family

I APPLY FOR COVERAGE AS INDICATED ABOVE – I have completed the above form and attest that all of the information provided is true and complete to the best of my knowledge. I understand that I am required to furnish proof of relationship for dependents added to the insurance coverage (marriage certificate, divorce decree, court documents establishing guardianship or adoption and/or the birth certificate for any individual for whom I seek benefits).

_____ _____
Signature of Applicant Date Signed

HRM Use Only

Dependent Verification Type:

*For HMO Participants:

Employee: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No

Dependent Name: _____

Medical Group/IPA#: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#:_____WPHCP (Medical Group Name): _____
Are you already a patient? ☐ Yes ☐ No