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?	Sex: □ M □ F
Primary language:		Race:	Ethnicity:	Check one: □ Active employee □ Retiree □ Survivor	
Are you covered by Medicare? Y/N	Part A effective:	Part B effective:	Medicare #	Department:	
				Phone (H):	Phone (W):

Effective Date:	□ New hire □ Open enrollment	Change to family: □ Add spouse □ Add dependent	Change to individual: □ Remove dependent(s)	□ Termination of employment □ Loss of coverage □ Other
	Remarks:			

Select one of the health plans below and indicate family or individual plan.			
□ City of Worcester Direct □ City of Worcester Advantage	□ Individual Plan	□ Family Plan	(Benefits office use only) Group# ID#

Dependent information				
Spouse/Ex-spouse: (Last/First/MI)	□ 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?		Medicare #:	
Dependent child: (Last/First/MI)	□ M □ F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	□ M □ F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	□ M □ F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	□ M □ F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP?	

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