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? Y/N	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 ☐ City of Worcester Advantage QHDP	☐ Individual Plan	☐ Family Plan	(Benefits office use only) Group# ID#

Dependent information:

Spouse/Ex-spouse: (Last/First/MI)	*Circle one:* 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? Y/N		Medicare #:	
Dependent child: (Last/First/MI)	M F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP? Y/N	
Dependent child: (Last/First/MI)	M F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP? Y/N	
Dependent child: (Last/First/MI)	M F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP? Y/N	
Dependent child: (Last/First/MI)	M F	Social Security #:	DOB: / /	PCP:
			Ever treated by this PCP? Y/N	

Employee signature: _____Date: _____ Employer signature: _____Date: _____

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