



EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

PCHP Group # 2021- _____

Anthem Dental Group # 033300- _____

HUMAN RESOURCES USE ONLY		HR Verification:	Effective Date:
<input type="checkbox"/> New Hire	<input type="checkbox"/> Change	<input type="checkbox"/> COBRA	<input type="checkbox"/> Retiree
<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Add Newborn	<input type="checkbox"/> Remove Dependents	<input type="checkbox"/> Open Enrollment
<input type="checkbox"/> Name Change (Previous name: _____)	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other	<input type="checkbox"/> Terminate Coverage

COMPLETE THIS SECTION ONLY IF MAKING A CHANGE DUE TO A QUALIFYING EVENT

Qualifying Event (Describe: _____) Date of Event: _____

Note: Qualifying Event changes must be made within 31 days of event. Examples include changes in family status such as marriage, divorce, adoption, loss of medical coverage, birth or death. Attach a copy of any documentation such as a letter stating loss of coverage, marriage license, etc. along with your enrollment/change form.

EMPLOYEE INFORMATION			
Social Security No.			
Employee Name			
Employee Address	Cell Phone:		
	Home Phone:		
Date of Birth	E-mail:		
Date of Hire			
Department/Location	Work Phone:		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed

Medical Coverage	
Level of Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> Family—Two Married City EEs <input type="checkbox"/> Waive

Dental Coverage	
Level of Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> Waive

Vision Coverage—changes only, complete Health Risk Assessment for initial enrollment	
Level of Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Dependent (Spouse or one child) <input type="checkbox"/> Family <input type="checkbox"/> Waive

Note: If you waive medical and/or dental or vision coverage, your next opportunity to enroll will be the next open enrollment period or if you have a qualifying event during the coverage period.

Dependent Information—Use extra form if necessary							
Spouse Name	SSN	Date of Birth	Gender	Spouse Work Full-Time for City?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Names	SSN	Date of Birth	Gender	Relationship	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Will you or any family member(s) listed above be covered by another health or dental care plan on the date this plan(s) becomes effective? <input type="checkbox"/> Yes <input type="checkbox"/> No					If you answered yes, please complete the following: Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Other		
Name of other insurance company or plan providing coverage:					Policy (or contract) Number:		

IMPORTANT—Please read and sign below:

I hereby apply for membership or request a change in membership and authorize my employer to deduct from my wages the amount required (if any) to cover my contributions(s) for medical, dental, and/or vision coverage. I understand that medical and dental dependent deductions will be withheld on a pre-tax basis unless I notify HR otherwise. I understand that my enrollment and benefits are in accordance with those described in the applicable plan document. I authorize 1) all health providers and insurers to furnish to PCHP/Delta Dental/Superior Vision and 2) all health providers' and PCHP/Delta Dental/Superior Vision to furnish to all insurers and health providers records concerning me or any members of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing the authorization for disclosure of information. A photographic copy of this authorization shall be as valid as the original.

SIGNATURE: _____

DATE: _____

RETURN COMPLETED FORM TO:

HUMAN RESOURCES DEPARTMENT
 900 Church Street, 3rd Floor, Lynchburg, VA 24504
 FAX: (434) 845-4304 PH: (434) 455-4200