MUTUAL HEALTH SERVICES℠

ENROLLMENT/CHANGE FORM

☐ **Enrollment** ☐ **Change** ☐ **Termination** **Effective Date:** _____

EMPLOYER: **HEIDELBERG UNIVERSITY**	DIVISION: ☐ Waiver ☐ Berg Benefits Plan
EMPLOYEE NAME: *Last, First, Middle:*	*E-mail:*
ADDRESS: *Number & Street:*	*Apt. #:*
City: *State:* *Zip:*	*Phone:*

☐ Male ☐ Female	HIRE/REHIRE DATE:	DATE OF BIRTH:	SOCIAL SEC. #[1]:	CURRENT MARITAL STATUS ☐single ☐widowed ☐married ☐divorced	IF STATUS CHANGE: Date of change / /

[1]Social Security numbers are required *for all participants* (employee and dependents) of the plan. This number will not appear on your ID card.
CMS Reporting requires the plan to report this information to Medicare administration.

Benefit Selection ☐ **Employee Only** ☐ **Employee + Spouse / Partner** ☐ **Employee + Child(ren)** ☐ **Family**

DEPENDENTS TO BE ENROLLED

LAST NAME, FIRST NAME, MID INIT	RELATIONSHIP[3]	SEX	BIRTH DATE	SOCIAL SECURITY #[1]	OTHER INSURANCE
Spouse:		☐ M ☐ F			☐ Yes ☐ No
[2]Child:		☐ M ☐ F			☐ Yes ☐ No
[2]Child:		☐ M ☐ F			☐ Yes ☐ No
[2]Child:		☐ M ☐ F			☐ Yes ☐ No
[2]Child:		☐ M ☐ F			☐ Yes ☐ No

[2]Proof of eligibility may be required. [3]Relationship examples: Spouse, Son, Daughter, Stepchild, Adopted Child, Other (specify).

OTHER INSURANCE ☐ **No members of my family are covered by any other plan of insurance.**
☐ **The following members are covered by other insurance plans as noted below.**

	EMPLOYEE	SPOUSE	CHILD:	CHILD:
Policy Holder's Name:				
Insurance Company:				
Coverage Tier:	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY
Coverage Type:	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION	☐ MEDICAL ☐ DENTAL ☐ RX ☐ VISION

Authorization: I hereby certify that the information on this application is true and accurate to the best of my knowledge and belief. I realize that any material misstatement, misrepresentation or omission may be grounds for voiding or retroactive termination of coverage. I hereby authorize and direct any holder of medical information (including, but not limited to, diagnosis, treatment, advice, and prognosis) about me or any individual receiving coverage pursuant to my enrollment herein to provide such information to Mutual Health Services. I hereby represent that I am the parent/legal guardian of all dependents enrolled hereby who are under 18 years of age and that I have the consent of each individual enrolled hereby who has attained the age of 18 to authorize the release of such information.

Signature of Employee_____ **Date Signed** _____

COMPLETE THIS SECTION ONLY IF YOU WISH TO WAIVE PART OF THE COVERAGE OFFERED

Waiver: I hereby certify that I have been given an opportunity to participate in the Employee Benefit Plan. The benefits of the plan have been thoroughly described to me, and I decline to participate. I understand that if, at a future date, I wish to apply for the benefits so waived, I may do so only as designated by the Plan Document.

Waiver of Coverage for: ☐ Medical/Rx Reason for Waiving _____

Signature of Employee_____ **Date Signed** _____

Signature of Employer_____ **Date Signed** _____