BUCKS AND MONTGOMERY COUNTY SCHOOLS
HEALTH CARE CONSORTIUM

NEW HOPE-SOLEBURY SCHOOL
DISTRICT HEALTH INSURANCE 2018-2019

Eligible employees will be covered on the first day of employment.
Upon initial enrollment eligible employees may enroll as a new enrollment, and add eligible family members to their group health plan.
Social Security Numbers and Birth Certificates are required, and should be attached, in order to add any qualified dependent.

Please see the table below for the plan names for your and Rx plans

Aetna Plan Name
BMCS Open Choice 1
BMCS POS
BMCS Open Choice 2

Select one of the options below and return the completed form(s) to Megan Candido, Human Resources within 30 days of your hire date. Forms will not be accepted subsequent to this date.

○..... **New enrollee or changing** type of coverage---**complete the information on the back of this form, sign below and return form**

○..... **Electing to waive** the School's group health insurance during the 2018-2019 Plan Year---**sign and return form**

Employee Print Name _____ Employee Signature _____ Date _____

Section I: **Employee/Contract Holder Information** **Effective Date**_____

☐ **Type of Coverage:** ☐ **Employee** ☐ **Employee/Child** ☐ **Employee/Children** ☐ **Employee/Spouse** ☐ **Family**

Type of Plan: ☐ **BMCS Open Choice 1 (10/20/70)** ☐ **BMCS Open Choice 2 (20/40/70)** ☐ **BMCS POS**

Name: _____ Phone (_____) _____

Address: _____City:_____State:_____Zip_____

Only complete if you are selecting the POS Plan. PCP #_____ PCP Name _____ PCP Address _____

Date of Birth: _____ Social Security Number: _____

Section II **Spouse/Dependent Information**

☐ **Add Spouse** ☐ **Remove Spouse**

Name: _____ Phone (_____) _____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name _____ PCP Address _____

Date of Birth: _____ Social Security Number: _____

Marriage/Divorce Date: _____ (**newly married/divorced couples must attach a copy of marriage license/divorce decree**)

☐ **Add Dependent** ☐ **Remove Dependent** ☐ Check here if dependent is disabled.

Name: _____ Date of Birth_____ Social Security Number_____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name_____ PCP Address _____

☐ **Add Dependent** ☐ **Remove Dependent** ☐ Check here if dependent is disabled.

Name: _____ Date of Birth_____ Social Security Number_____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name_____ PCP Address _____

☐ **Add Dependent** ☐ **Remove Dependent** ☐ Check here if dependent is disabled.

Name: _____ Date of Birth_____ Social Security Number_____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name_____ PCP Address _____

☐ **Add Dependent** ☐ **Remove Dependent** ☐ Check here if dependent is disabled.

Name: _____ Date of Birth_____ Social Security Number_____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name_____ PCP Address _____

☐ **Add Dependent** ☐ **Remove Dependent** ☐ Check here if dependent is disabled.

Name: _____ Date of Birth_____ Social Security Number_____

Only complete if you are selecting the POS Plan. PCP # _____ PCP Name_____ PCP Address _____