NEW HOPE-SOLEBURY SCHOOL
DISTRICT HEALTH INSURANCE 2019-2020

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 Open Choice 2
BMCS Open Choice 3 (Support Staff Only)
BMCS POS

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 2019/2020 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** ☐ **BMCS Open Choice 2** ☐ **BMCS Open Choice 3 (Support Staff Only)** ☐ **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 ________________________