



BUCKS AND MONTGOMERY COUNTY SCHOOLS  
HEALTH CARE CONSORTIUM

**NEW HOPE-SOLEBURY SCHOOL  
DISTRICT HEALTH INSURANCE 2021-2022**

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 Chris Schwartz, 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 2022/2023 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  FamilyType 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)

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 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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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