

Employee ID#

New Castle County
GROUP APPLICATION/CHANGE FORM

Effective Date

Please Type or Print Bold

1. PERSONAL INFORMATION

Form with fields for Social Security Number, Date of Birth, Last Name, First Name, MI, Street Address, City, State, Zip, Home Phone Number, Home Email, Work Phone Number.

2. TYPE OF APPLICATION

- Options for application type: New Application include Date of Hire, Open Enrollment, Add Family Member, Remove Family Member, Address Change, Name Change.

Reason for Change:

- Options for reason for change: Marriage, Divorce, Birth, Death, Other, Date of Event.

3. COVERAGE INFORMATION - Is this a change in coverage: HEALTH OR DENTAL Yes No

4. MEDICAL COVERAGE (Select One) Please check the coverage(s) you want.

Form for selecting medical coverage options: Aetna Select HMO, Highmark Comp 80, Highmark BlueCare EPO, Highmark PPO, EyeMed Vision Plan, WAIVE - Health Coverage.

5. DENTAL COVERAGE (Select One)

6. CANCEL COVERAGES

Form for selecting dental coverage and canceling coverages (Medical, Dental, Vision).

8. Complete the information for yourself and any dependents being provided coverage. For additional dependents attach a separate list (if necessary).

Add	Remove	Continue	Name (Include last name if different from applicant)	SEX	DATE OF BIRTH Month/ Day/Year	SOC SEC NUMBER	✓ IF DEPENDENT TO BE COVERED BY MEDICAL	✓ IF DEPENDENT TO BE COVERED BY DENTAL	✓ IF DEPENDENT TO BE COVERED BY VISION	DISABLED (PLEASE ATTACH VERIFICATION)	
										Yes	No
			Self	<input type="checkbox"/> M <input type="checkbox"/> F							
			Spouse	<input type="checkbox"/> M <input type="checkbox"/> F							
			Child(ren)	<input type="checkbox"/> M <input type="checkbox"/> F						Yes <input type="checkbox"/>	No <input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F						Yes <input type="checkbox"/>	No <input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F						Yes <input type="checkbox"/>	No <input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F						Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please indicate other health besides coverage through NCC for which YOUR dependents are currently enrolled:

Name of Insured	Name of Plan	Plan Location (City, State)	ID or Policy No.
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If removing family member, please provide his/her current address:

Name	Address	City, State, Zip
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1. Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and health carrier.
2. I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.
3. I authorize my employer, as my agent, if applicable to collect premiums by payroll deduction, for remittance to the carrier, with the understanding that payment will not be complete until actually received by the carrier.
4. I authorize any physician, hospital or any other health care provider to release information available to them as to diagnosis, treatment or any other health care services they render to me or my covered dependents to my designated carrier or their legal representative.
5. I also authorize my designated carrier to release appropriate diagnostic and medical information to other persons in connection with a claim for coordination of benefits, or other purposes related to this contract.

9. PLEASE SIGN AND DATE BELOW:

The information supplied on this application is accurate and complete to the best of my knowledge and I have read and agree to the terms set forth on the reverse side of this form.

Sign Here →

Date