



**Preferred Provider Option (PPO) Plans**

- High Benefit Level (low deductible)
- Low Benefit Level\* (high deductible)

\*Not available to Local 587

**EMPLOYEE Enrollment / Change Form**

- Open Enrollment     New Employee     Change (complete change section)

Benefits Administered by



GROUP NUMBER	CLASS #	EMPLOYEE JOB LOCATION	EFFECTIVE DATE
-----HR USE ONLY-----			

**Section 1 \*ALL EMPLOYEES COMPLETE SECTION 1**

EMPLOYEE START DATE	JOB TITLE	SOCIAL SECURITY #	EMAIL ADDRESS
LAST NAME		FIRST NAME	M.I.
ADDRESS		CITY	STATE ZIP
DATE OF BIRTH	SEX (M/F)	MARITAL STATUS	HOME PHONE # WORK PHONE #
EMPLOYEE STATUS	UNION		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Non-represented <input type="checkbox"/> Local 212 Teacher <input type="checkbox"/> Local 212 Para <input type="checkbox"/> Local 587 <input type="checkbox"/> Local 715		
TYPE OF COVERAGE: <input type="checkbox"/> Employee only <input type="checkbox"/> Family (Employee plus dependent(s))			

**Section 2 \*\* New enrollees complete Sections 2, 3 & 4\*\***

Do you or any eligible dependent have other health coverage as of the effective date of enrollment?    Yes, single    Yes, family    No

If yes to the above question, complete the following:

Person's name \_\_\_\_\_

Employer Name \_\_\_\_\_ Carrier Name \_\_\_\_\_ Plan Number \_\_\_\_\_

Person's name \_\_\_\_\_

Employer Name \_\_\_\_\_ Carrier Name \_\_\_\_\_ Plan Number \_\_\_\_\_

**Section 3**

Are you or any of your dependents eligible for Medicare benefits?    No    Yes

If yes, Name \_\_\_\_\_, and Medicare Member # \_\_\_\_\_

Name \_\_\_\_\_, and Medicare Member # \_\_\_\_\_

Name \_\_\_\_\_, and Medicare Member # \_\_\_\_\_

**IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.**

**SEE REVERSE**

**Section 4**

Last Spouse Name	First	MI	SS#	BIRTH DATE	SEX			
_____	_____	_____	_____ - _____ - _____	____/____/____	_____			
Domestic Partner*								
_____	_____	_____	_____ - _____ - _____	____/____/____	_____			
Dependent Name(s)			SS#	BIRTH DATE	SEX	Relation to Employee	Do you provide more than 50% support?	Is dependent disabled?
1 _____			_____ - _____ - _____	____/____/____	_____	_____	_____	_____
2 _____			_____ - _____ - _____	____/____/____	_____	_____	_____	_____
3 _____			_____ - _____ - _____	____/____/____	_____	_____	_____	_____
4 _____			_____ - _____ - _____	____/____/____	_____	_____	_____	_____
5 _____			_____ - _____ - _____	____/____/____	_____	_____	_____	_____

\*Same sex partner only; does not apply to Local 587. Must attach supporting documentation (see HR for appropriate forms).

### Change to Coverage or Personal Information

**Section 5** – Complete this section if currently enrolled in the PPO plan and are reporting changes

Effective date of change: _____	<b>Please specify change and update in appropriate section.</b>		
<input type="checkbox"/> Employee name change	<input type="checkbox"/> Employee address change	<input type="checkbox"/> Termination	<input type="checkbox"/> Adoption
<input type="checkbox"/> Birth (Copy of birth certificate required)	<input type="checkbox"/> Date of marriage (Copy of marriage certificate required) _____		
<input type="checkbox"/> Date of divorce _____	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Add dependents	<input type="checkbox"/> Remove dependents	Reason: _____	
Spouse	SS#	Birth Date	Sex
_____	_____	_____	_____
Domestic Partner*	SS#	Birth Date	Sex
_____	_____	_____	_____
Dependent	SS#	Birth Date	Sex
_____	_____	_____	_____
Dependent	SS#	Birth Date	Sex
_____	_____	_____	_____

\*Same sex partner only; does not apply to Local 587. Must attach supporting documentation (see HR for appropriate forms).

**Signature and date are required.**

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Please refer to your Employee Benefit Booklet for specific details of your benefit plan.

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

\_\_\_\_\_  
**EMPLOYEE SIGNATURE**

\_\_\_\_\_  
**DATE**

*MATC is an Affirmative Action/Equal Opportunity institution and complies with all requirements of the Americans with Disabilities Act.*

HR USE ONLY	
COSMO _____	Quantum _____
UMR _____	SPD _____
Billing _____	(PT Only)