Employee ID#

New Castle County
GROUP APPLICATION/CHANGE FORM

Please Type or Print Bold

Effective Date

1. PERSONAL INFORMATION

Social Security Number [redacted]		**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

☐ New Application include Date of Hire: _____ ☐ Open Enrollment ☐ Add Family Member ☐ Remove Family Member

☐ ***Address Change:*** From: _____ To:_____

☐ ***Name Change:*** From: _____ To _____

Reason for Change:

☐ Marriage ☐ Divorce ☐ Birth ☐ Death ☐ Other | **Date of Event**

3. MEDICAL COVERAGE (Select One) Please check the plan and coverage level.

Medical Coverage Active Employees
☐ **Aetna Select HMO (834912-010-00001)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family4.
☐ **Highmark Comp 80 (10006183)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family
☐ **Highmark BlueCare EPO (10055812)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family
☐ **Highmark PPO (10006173)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family

4. VISION COVERAGE

❑ **EyeMed Vision Plan (1002649)**
☐ Individual ☐ Individual/Spouse
☐ Individual/Child(ren) ☐ Family

☐ **WAIVE – Health Coverage**

5. DENTAL COVERAGE (Select One)

DOMINION DENTAL HMO (SELECT PLAN, GRP.# 21546)
☐ Individual only
☐ Family
DENTAL PROVIDER NAME & ID# (One Dentist per family)

METLIFE PPO DENTAL (HIGH DENTAL PLAN)
(Group # 0243083 Sub-location 001)
☐ Individual only
☐ Emp. + One
☐ Family

METLIFE PPO DENTAL (MEDIUM DENTAL PLAN)
(Group # 0243083 Sub-location 002)
☐ Individual only
☐ Emp. + One
☐ Family

METLIFE PPO DENTAL (LOW DENTAL PLAN)
(Group # 0243083 Sub-location 003)
☐ Individual only
☐ Emp. + One
☐ **Family**

6. CANCEL COVERAGES

CANCEL COVERAGES (MEDICAL)
☐ Aetna Select HMO ☐ Highmark Comp 80
☐ Highmark EPO ☐ Highmark PPO

Effective Date: _____

CANCEL COVERAGES (DENTAL)
☐ Dental HMO Select Plan ☐ Dental PPO Low Plan
☐ Dental PPO Medium Plan ☐ Dental PPO High Plan

Effective Date: _____

CANCEL COVERAGES (VISION)
☐ EyeMed **Effective Date: _____**

7. 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)
			Self	☐ M ☐ F						
			Spouse	☐ M ☐ F						
			Child(ren)	☐ M ☐ F						Yes ☐ No ☐
				☐ M ☐ F						Yes ☐ No ☐
				☐ M ☐ F						Yes ☐ No ☐
				☐ M ☐ F						Yes ☐ No ☐

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.

If removing family member, please provide his/her current address:

Name	Address	City, State, Zip

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.**

8. 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 _____