EMPLOYEE ID#_____

Date Of Hire: _____

NEW CASTLE COUNTY

GROUP APPLICATION/CHANGE FORM PAGE 1

Effective Date

PERSONAL INFORMATION

Social Security Number	[redacted]	Date of Birth:
Last Name	First Name	MI
Street Address	City/State	Zip Code
Personal Phone Number	Personal Email	Work Phone Number

1. TYPE OF APPLICATION

☐ New Application ☐ Open Enrollment ☐ Add Family Member ☐ Remove Family Member ☐ Address/Name Change

Reason for Change:

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

2. 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.
☐ **Aetna PPO (834912-010-00001)** ☐ 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
☐ **Aetna Qualified High Deductible (834912-025-00001)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family ☐ **HSA (Health Savings Account Contribution $_____ (Year) (High-Deductible Plan only)**
☐ **Highmark Passive PPO (10006183)** ☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family

3. VISION COVERAGE

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

☐ **WAIVE – Health Coverage**

4. 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**

5. CANCEL COVERAGES

CANCEL COVERAGES (MEDICAL)
☐ Aetna Select HMO ☐ Aetna High Deductible
☐ Aetna PPO ☐ Highmark PPO
☐ Highmark EPO ☐ Highmark Passive 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:** _____

NEW CASTLE COUNTY

GROUP APPLICATION/CHANGE FORM PAGE 2

6. Complete the information for yourself and any dependents who will be covered. If you need additional space, please attach a separate list.

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 any other health coverage, besides NCC, in which YOUR dependents are currently enrolled:

Name of Insured	Name of Plan	Plan Location (City, State)	ID or Policy No.

If you remove a family member, please provide their 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 provider.**
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 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 authorize my designated carrier to release appropriate diagnostic and medical information to other companies in connection with a claim for coordination of benefits, or other purposes related to this contract.**

7. PLEASE SIGN AND DATE BELOW:

I certify that the information provided on this application is accurate and complete to the best of my knowledge. I have read and agree to the terms stated on the reverse side of this form.

Sign Here → _____ Date _____