Enrollment and Membership Change Form
Local 933 "Opt Out" Participants ONLY
DENTAL ONLY

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt.#

City | State | Zip Code

Home Telephone | Work Telephone

Marital Status
☐ Single ☐ Legally Separated ☐ Widowed
☐ Married ☐ Separated ☐ Divorced

Email address

2. Membership

☐ ENROLLMENT (add dep)

☐ CANCEL

Reason_______________________

3. Change Membership

CHANGE:
☐ ADDRESS (indicate **NEW** address at left)
☐ NAME (Indicate **Former** Name below)
____
☐ OTHER REASON (Birth, Marriage, Divorce, Loss of Coverage Event etc.)
____
____

EVENT DATE ____MM/____DD/____YY

To Be Completed By Employer

Requested Effective Date
MM/DD/YY

Firm Division No

Health Benefit Plan
DENTAL ONLY

For Office Use Only

Form revised 04/2020

4. Your Membership Choices – Local 933

	Individual	Two Person	Family	
☐ DENTAL	☐	☐	☐	950

Please note that this application is for participants of the Medical Benefits Opt Out Waiver who elect Dental ONLY. As an eligible member of Local 933 participating in the Medical Benefit Waiver Opt Out program, you may elect Dental coverage for yourself and your family while remaining in the Opt Out program.

5. Where You Work

Department/Division Name
BOARD OF EDUCATION, LOCAL 933 TEACHERS

Only complete and return this form if you are keeping, adding, changing, or cancelling Dental coverage AND you are a current participant in the Medical Benefit Opt Out program.

DATE OF FULL TIME HIRE

6. List Members to be included on Dental

Gender	Name (First/Middle/Last)	Add	Cancel	Social Security Number	Date of birth (MM/DD/YY)	
☐M ☐F	Self					
☐M ☐F	Spouse					
☐M ☐F	Dependent					
☐M ☐F	Dependent					
☐M ☐F	Dependent					
☐M ☐F	Dependent					

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage?
If yes, please fill in the information below ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policy Holder)	Policy or ID No.	Reasons For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (self)	Are you actively at work? ☐ YES ☐ NO	Retired Date MM/DD/YY	Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date MM/DD/YY

Medicare No. | **EFFECTIVE DATES** Medicare A (Hospital) MM/DD/YY | Medicare B (Medical) MM/DD/YY

Medicare No. | **EFFECTIVE DATES** Medicare A (Hospital) | Medicare B (Medical)

I understand that false and or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date
MM / DD / YY

If you enroll in these group dental benefits available to you as an employee of the City of New Haven, your share of premiums will be deducted from your pay tax-free. However, participation is voluntary.

INSTRUCTIONS

Please print all information

THANK YOU FOR CHOOSING OUR PLAN

How to Fill out This Form – Press Firmly – Please Use Ballpoint Pen

Please read the instructions before filling out he attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/canceling eligible dependents, or changing a primary care physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCE	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice.
B. Please Check Individual, two person, or family.

5. Where You Work

Please complete all information in this section

6. List Members to Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers and date of birth.
B. Indicate Last name if different.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare/Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your benefits coordinator. Save a copy of this form for your records until you receive you identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.