City of Worcester Advantage Insurance Enrollment and Change Form

Check one: ☐ **Settled** ☐ **Non-Settled**

Employee Information Last name	First name	MI	Social Security #	DOB:
Address:			PCP name:	DOH:
City:	State:	Zip Code:	Ever treated by this PCP?	Sex: ☐ M ☐ F
Primary language:	Race:	Ethnicity:	Check one: ☐ Active employee ☐ Retiree ☐ Survivor	
Are you covered by Medicare? Y/N / Part A effective:	Part B effective:	Medicare #	Department:	
			Phone (H):	Phone (W):

Effective Date	☐ New hire ☐ Open enrollment	Change to family: ☐ Add spouse ☐ Add dependent	Change to individual: ☐ Remove dependent(s)	☐ Termination of employment ☐ Loss of coverage ☐ Other
	Remarks:			

Select one of the health plans below and indicate family or individual plan			
☐ City of Worcester Direct ☐ City of Worcester Advantage	☐ Individual Plan	☐ Family Plan	(Benefits office use only) Group# ID#

Dependent information				
Spouse/Ex-spouse: (Last/First/MI)	☐ M ☐ F	Social Security #	DOB: / /	Are you covered by Medicare? Y/N
			Part A effective:	Part B effective:
PCP name:	Ever treated by this PCP?		Medicare #:	
Dependent child: (Last/First/MI)	☐ M ☐ F	Social Security #	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	☐ M ☐ F	Social Security #	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	☐ M ☐ F	Social Security #	DOB: / /	PCP:
			Ever treated by this PCP?	
Dependent child: (Last/First/MI)	☐ M ☐ F	Social Security #	DOB: / /	PCP:
			Ever treated by this PCP?	

Employee signature: _____ Date: _____ Employer signature: _____ Date: _____