City of Portland Point of Service Employee Health Enrollment/Change Form
389 Congress St., Portland, ME 04101

Use black or blue ink only.

1. Subscriber/Applicant Information

Last Name | First Name | M.I.

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

City | State | Zip Code

Home Telephone ( ) | Work Telephone

Date of Hire ___/___/___ | Date of Rehire (if applicable) ___/___/___ | Date Eligible ___/___/___ | #Hours Worked per week

2. Enrollment Reason

- ☐ New Hire ☐ Annual Enrollment
- ☐ Portability or Qualifying Life Event
- ☐ Other _____

City of Portland Use Only

Suffix:

Account:

3. Change Status. Please check the reason(s) for change below.

Type of Change: ☐ Name Change ☐ Enroll ☐ Delete

Reason for Change. Please check all that apply:

☐ Marriage	☐ Birth	☐ Adoption
☐ Death	☐ Divorce	☐ Involuntary Loss of Coverage
☐ Involuntary Loss of Medicaid	☐ Covered by Medicaid	☐ Covered by Other Insurance
☐ Annual Enrollment	☐ Entrance to the Military	☐ Discharge from the Military
☐ Court Order changing custody	☐ Court Order	☐ Address Change

☐ Other: _____ **Date of Change or Event** _____

☐ Hours Change

4. Applicant and Member Information *(list only family members you wish to enroll, delete or change)*

To be eligible, a dependent child must be under 26 years of age. A domestic partner may be covered upon completion of the domestic partner affidavit form.

Sex	Names of Person(s) Last Name	First Name	M.I.	Is anyone covered by other insurance?	If Disabled, date of disability	Social Security #	Birth Date	In order to enroll, you must select a Primary Care Physician. Find high value network and Aetna network doctors and providers at www.portlandmaine.gov. Choose Departments>Human Resources>Benefits>Health Plan.
☐M ☐F	Self			☐Y ☐N				Name / Aetna PCP Provider Number
☐M ☐F	☐ Legal Spouse or ☐ Domestic Partner (DP)			☐Y ☐N				Name
☐M ☐F	Child			☐Y ☐N				Name
☐M ☐F	Child			☐Y ☐N				Name
☐M ☐F	Child			☐Y ☐N				Name

Are you or any family members currently claiming Workers' Comp Medical Benefits? ☐ Yes ☐ No *If yes, name of claimant:* _____

5. Address of Former Dependent for COBRA Notification

Last | First | MI

Street | City | State | Zip

6. Other Medical Coverage

If you checked 'Yes' to Other Medical Medical Coverage above, provide effective dates, name and policy number of insurance carrier or other source and medical identification number.

7. Applicant Signature

I am requesting coverage for myself and all dependents listed on this form, and I authorize my employer to deduct any required contributions for this coverage from my earnings. All statements and answers I have given are true and complete to the best of my knowledge. I understand that if I have provided any false, incomplete, or misleading information, then my coverage under this plan may be null and void and may result in a denial of all benefits. I understand that all benefits are subject to the terms and conditions stated in the Summary Plan Description (SPD).

Applicant Signature _____ Print Name _____ Date ___/___/___

8. Election Not to Enroll

If you are declining enrollment in the Plan for yourself or your dependents because you and dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 60 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Signature _____ Date ___/___/___