

MUNICIPAL BENEFITS SERVICES (MBS) MEMBER ENROLLMENT/CHANGE FORM

Please fill out this form in its entirety. Completed forms should be returned via the Client Portal as a ticket attachment. Changes must be received within 30-days of the qualifying event.



TYPE OF ACTIVITY:

- ☐ New Enrollment
☐ Cancel All Coverage

Reason: ☐ Voluntary ☐ Involuntary

Please explain: _____

- ☐ Change:
☐ Self Only
☐ Add Dependent(s)
☐ Remove Dependent(s) Only
☐ Name/Address Change
☐ Move to Retiree Group
☐ Change Division

ENROLLMENT STATUS:

- ☐ Single
☐ Employee/Spouse
☐ Parent/Child
☐ Parent/Children
☐ Family

ENROLLMENT STATUS:

- ☐ Highmark
☐ Highmark Performance Blue
☐ UPMC

TYPE OF COVERAGE TO ADD OR CANCEL:

- ☐ Medical Plan/Division # _____
☐ Dental Plan/Division # _____
☐ Vision Plan/Division # _____

DATE OF QUALIFYING EVENT: _____

EFFECTIVE DATE FOR CHANGE: _____

WAITING PERIOD: _____

Life Insurance Volume: \$ _____

Effective Date: _____

AD&D Volume: \$ _____

Effective Date: _____

☐ STD ☐ LTD ☐ PRDB ☐ Widows Benefit

EMPLOYEE ANNUAL SALARY:

Employee Annual Salary: \$ _____

Municipality Name: _____ Employee Division (Police, Fire, Admin, etc.): _____ Occupation: _____

Employee Last Name: _____ Employee First Name: _____ Employee SSN #: _____

Employee DOB: _____ Gender: ☐ Male ☐ Female ☐ Other Employee Date of Hire: _____ Employee Phone #: _____

Employee Address _____ Employee City/State _____ Employee Zip Code _____

Please note, when adding/enrolling dependents, proper documentation is required (i.e. Marriage Certificate, Birth or Adoption Papers).

Dependent SSN #	Relationship to Employee	Dependent Last Name	Dependent First Name	Dependent Middle Initial	Gender	DOB	Add/Change/Terminate

I represent that all information supplied in this application is true and correct. Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of Claim containing any materially false or conceals for the purpose of misleading information concerning any fact material thereto commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Employee Signature

Date

Employer Signature

Date