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.

Municipal Benefits Services

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

EMPLOYEE ANNUAL SALARY:

Employee Annual Salary: $_____

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

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**