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 MEMBER ENROLLMENT/CHANGE FORM

TYPE OF ACTIVITY:

- ☐ New Enrollment
- ☐ Cancel All Coverage:
  - Reason: ☐ Voluntary ☐ Involuntary
  - Please Explain:
- ☐ Change:
  - ☐ Add Dependent(s)
  - ☐ Cancel Dependent(s) Only
  - ☐ Name/Address Change
  - ☐ Move to Retiree group

EMPLOYEE ANNUAL SALARY:

ENROLLMENT STATUS:

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

MEDICAL CARRIER/NETWORK:

- ☐ Highmark
- ☐ UPMC

TYPE OF COVERAGE TO ADD OR CANCEL:

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

DATE OF QUALIFYING EVENT:

EFFECTIVE DATE (OF ADD/TERM/CHANGE)

WAITING PERIOD:

Life Insurance: Volume

Effective Date

A&D: Volume

Effective Date

☐ STD ☐ LTD ☐ PRDB ☐ Widows Benefit

Municipality Name: | Employee Class (Police, Fire, Admin, etc.): | Occupation:

Employee Last Name: | Employee First Name: | Employee SSN #:

Employee DOB: | Gender: | Employee Date of Hire: | Employee Phone #:

Employee Address:	Employee City/State:	Employee Zip:

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	Sex	Date of Birth	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