Putnam/Northern Westchester Health Benefits Consortium
Enrollment/Change Request

Employer Name	**Suffix**	**Account**

Employee Name	**Effective Date**	**Employment Status** ☐ Active ☐ Retired
Social Security Number	**Birthdate**	**Sex** ☐ Male ☐ Female ☐ Other

Employee Home Address (Street, City, Zip)	**Phone number**	**Email address**

Transaction Type	**Remove or terminate**	**Continuation of coverage (COBRA)**
☐ New Enrollee	☐ Remove spouse	☐ Employee continuation coverage
Hire Date_______/_______/_______	☐ Remove dependent child	Effective Date ________________________
☐ Add spouse	☐ Employee termination	☐ Dependent continuation coverage
Date of Marriage_____/_____/_____	☐ Cancel coverage	Effective Date ________________________
☐ Add dependent child	**Effective date:**___________________________	Continuation of coverage expiration date:
☐ Name Change	**Reason:**_________________________	______________________
☐ Other ______________________		
*Marriage certificates required as well as birth certificates for children.		

Individuals covered

Dependent Name	SSN	Relationship code	Birthdate MM/DD/YYYY	Add/Change/Cancel

Please complete reverse side

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Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed on this form, I agree to or with the following:

1. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
2. I understand and agree that this Enrollment/ Change Request may be transmitted to the Plan or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers") to give the Plan or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/ Change Request form, including those involving mental health, substance abuse and HIV/ AIDS. I further authorize the Plan to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization· within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
3. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. I understand and agree that all participating providers and vendors are independent contractors and are neither agents nor employees of the Plan or its agent. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Employee Signature

I have read and agree to the terms of the authorization above. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that for any reason my School District does not receive notice of the above transaction request within a reasonable time following the event, me and my dependents' eligibility may be affected. I certify that all information supplied in this form is true and complete to the best of my knowledge and / or belief. I have read and agree to the Conditions of enrollment on this Enrollment I Change Request form.

Misrepresentation: Any person who 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee signature – required	**Date (Month/Day/Year)**	**Employer signature – required**	**Date (Month/Day/Year)**
X		**X**	