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**ENROLLMENT FORM**

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| --- | --- | --- | --- | --- | --- | --- |
| ENROLLMENT FORM FOR GROUP INSURANCE | | | | | | |
| Your employer provided information used to create this enrollment form. | | | | Group ID: | | | | Group Policy #: | | | | Billing Division or Location: | | | |
| **Employee Information (Complete for ALL Enrollments)** | | | | | | | | | | | | | | | |
| Employer Name/Company Name  **Town of Westminster** | | | | | | | | County | | Employer ZIP | | | | | State |
| Employee First Name / Middle Initial / Last Name | | | | | | | | Social Security Number | | | | | | | Date of Birth |
| Street Address / City / State / Zip | | | | | | | | | | | | | | | |
| Gender: | | Marital Status: | | | | Home Phone | | | | | Work Phone | | | | |
| Employee Work Information (Complete for ALL Enrollments) | | | | | | | | | | | | | | | |
| Average Work Week  Hours: | Occupation: | | | | Earnings: | | | | Full-Time Employment Date: | | | | Rehire Date: | | |
| **EFFECTIVE DATE: 07/01/2024** | | | | | | | | | | | | | | | |
| **Product Selection (Complete for ALL Enrollments)** | | | | | | | | | | | | | | | |
| **Voluntary Coverage NOTE**: Please mark the box or boxes for each coverage you are applying for.  All coverage amounts are subject to the limitations and exclusions as stated in the policy. | | | | | | | | | | | | | | | |
| Type of Coverage | | | Selecting yes authorizes my employer to payroll deduct premium(s) | | | | | Amount of Coverage | | | | | | Voluntary Pricing | |
| Vision  Provided By: MetLife | | | **Yes No\*** | | | | | **Employee Only**  **Employee/Spouse**  **Employee/Children**  **Employee/Spouse/Children** | | | | | | $5.20  $11.18  $11.42  $17.75 | |
| MetLife Aura Identity & Fraud Protection  Provided By: MetLife | | | **Yes No\*** | | | | | Individual  Family | | | | | | $6.95  $10.95 | |
| MetLife Aura Identity & Fraud Protection PLUS  Provided By: MetLife | | | **Yes No\*** | | | | | Individual  Family | | | | | | $9.95  $15.95 | |
| MetLife Legal Plan plus Divorce  Provided By: MetLife | | | **Yes No\*** | | | | | All Family Members | | | | | | $21.75 | |

\*By selecting no, application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense. Actual deductions may vary slightly from above illustration due to rounding

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Dependent and Other Insurance Information (Complete for All Dependent Coverage)** | | | | | |
|  | **Last Name** | **First Name** | **Social Security #** | Gender | Date of Birth |
| **Spouse:** |  |  |  |  |  |
| **Children:**  **Full Time Student \_\_\_\_** |  |  |  |  |  |
| **Full Time Student \_\_\_\_** |  |  |  |  |  |
| **Full Time Student \_\_\_\_** |  |  |  |  |  |

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Required Notice: Boon-Chapman Benefit Administrators, Inc. is a third party administrator that provides premium billing services for the insurance companies offering coverage under this Form.

**Signature Section:**

I acknowledge I have received and reviewed enrollment materials explaining the benefits offered and the exclusions, limitations and reductions that apply.  I understand that the effective date of coverage will vary based on contract terms.  I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected.  I understand that my payroll deduction amount will change if my coverage or costs change.  I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents.  The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program.  I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name:

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_