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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 WeekHours: | 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 |
| VisionProvided 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 ProtectionProvided By: MetLife      | **[ ] Yes [ ] No\***  | **[ ]** Individual **[ ]** Family  | $6.95$10.95 |
| MetLife Aura Identity & Fraud Protection PLUSProvided By: MetLife      | **[ ] Yes [ ] No\***  | **[ ]** Individual **[ ]** Family  | $9.95$15.95 |
| MetLife Legal Plan plus DivorceProvided 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

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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_