

2019 Open Enrollment High Deductible Enrollment Package

IT IS IMPORTANT THAT YOU READ ALL INSTRUCTIONS

YOU MUST CALL HUMAN RESOURCES TO SCHEDULE AN APPOINTMENT TO TURN IN THIS PACKET – (781) 431-1019 x2244

Please note that employees who have enrolled in a high deductible family plan, and have taken the early adopter bonus, cannot select a low deductible plan.

Use this enrollment packet if you want to:

- Sign up for new coverage
- Change existing coverage
- Designate Flexible Spending Account amount for dependent care
- Designate Health Savings Account amount
- Add/Delete dependents or spouse

Read the following before proceeding:

- This entire package must be turned in to Human Resources by appointment only by the Open Enrollment deadline
- You must indicate an action for each insurance by checking one of the boxes and then completing the corresponding form
- Forms must be fully completed
- Incomplete forms will not be able to be processed
- No extensions or exceptions will be granted for incomplete forms that are turned in

If you are adding a spouse or dependent to any insurance:

- You must include the social security number if it is required on the form
- The addition of the spouse requires a copy of the marriage certificate to be included with this packet at the time it is turned in
- The addition of a dependent requires a copy of the birth certificate to be included with this packet at the time it is turned in
- Please staple or attach copies of any marriage and/or birth certificates to the last page of this packet

Health Insurance

The following forms are for the high deductible plans for Fallon Select, Fallon Direct, Tufts, Harvard Pilgrim and Blue Cross Blue Shield.

If switching between insurances, you must first cancel your current insurance by completing their form, and then enroll in your new insurance by completing your new insurance form.

Any additions of a spouse and/or dependents must include the marriage and/or birth certificates. Failure to include the marriage and/or birth certificates will mean that addition will not be processed.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date

Member Transaction Form

Please print clearly and complete all applicable fields.



Fallon Health
Fallon Health & Life Assurance Co., Inc.

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

Group number	Group name	Effective date: (MM/DD/YYYY)
Please check off the reason you are filling out this form:		
Adding coverage: <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (Please explain in the Remarks section below.)		
Ending coverage: <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (Please provide the name of the other insurance in the Remarks section below.) <input type="checkbox"/> Other (Please explain in the Remarks section below.)		
Changes to existing coverage: (Please choose an option and explain in the Remarks section below.) Change to: <input type="checkbox"/> Individual plan <input type="checkbox"/> Family plan <input type="checkbox"/> COBRA <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event: _____ <input type="checkbox"/> Removal of a dependent <input type="checkbox"/> Change in name, address or other application information <input type="checkbox"/> Other		
Remarks:		

This form is not complete without an authorized employer signature on page 2.

THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE EMPLOYEE (subscriber):

Please complete all applicable fields in this section.

Provider network: <input type="checkbox"/> Direct Care* <input type="checkbox"/> Select Care <input type="checkbox"/> Fallon Preferred Care <input type="checkbox"/> Steward Community Care* <input type="checkbox"/> Tiered Choice*			
Plan name: _____			
First name	Middle initial (MI)	Last name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Maiden name	Primary language	Birth date (MM/DD/YYYY)	
Street address			
City	State	ZIP code	
Mailing address (if different from street above)			
City	State	ZIP code	
Would you be interested in receiving communications from Fallon via email? If so, please check the box and provide your email address: <input type="checkbox"/>			Home phone
Social Security #**	Date hired (MM/DD/YYYY)	Work phone	
Race (please choose one) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other			
Work status (please choose one) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			
Average # of hours worked weekly	Department #	Employee #	
Does your spouse have health insurance from another source? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide the name of your selected primary care provider (PCP). Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First name	MI	Last name	

Benefits administrator: Please mail the white and yellow copies of this form to: Fallon Health Service Operations, 10 Chestnut St., Worcester, MA 01608.
The pink copy is for the employee.

DEPENDENT SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

Dependent 1: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 2: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 3: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 4: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 5: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.

X _____
Employee signature (REQUIRED) Print name here Date

X _____
Employer signature (REQUIRED) Print name here Date

Group name (please print) _____

* Direct Care, Steward Community Care and Tiered Choice provide access to networks that are smaller than the Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care, Steward Community Care and Tiered Choice.

Tiered Choice members have access to network benefits only from the providers in Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.

**Required for tax purposes

Member Transaction Form

Please print clearly and complete all applicable fields.



Fallon Health
Fallon Health & Life Assurance Co., Inc.

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

Group number	Group name	Effective date: (MM/DD/YYYY)
Please check off the reason you are filling out this form:		
Adding coverage: <input type="checkbox"/> New hire <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> Other (Please explain in the Remarks section below.)		
Ending coverage: <input type="checkbox"/> Termination of employment <input type="checkbox"/> Change to other insurance (Please provide the name of the other insurance in the Remarks section below.) <input type="checkbox"/> Other (Please explain in the Remarks section below.)		
Changes to existing coverage: (Please choose an option and explain in the Remarks section below.) Change to: <input type="checkbox"/> Individual plan <input type="checkbox"/> Family plan <input type="checkbox"/> COBRA <input type="checkbox"/> Other <input type="checkbox"/> Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event: _____ <input type="checkbox"/> Removal of a dependent <input type="checkbox"/> Change in name, address or other application information <input type="checkbox"/> Other		
Remarks:		

This form is not complete without an authorized employer signature on page 2.

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Please complete all applicable fields in this section.

Provider network: <input type="checkbox"/> Direct Care* <input type="checkbox"/> Select Care <input type="checkbox"/> Fallon Preferred Care <input type="checkbox"/> Steward Community Care* <input type="checkbox"/> Tiered Choice*			
Plan name: _____			
First name	Middle initial (MI)	Last name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Maiden name	Primary language	Birth date (MM/DD/YYYY)	
Street address			
City	State	ZIP code	
Mailing address (if different from street above)			
City	State	ZIP code	
Would you be interested in receiving communications from Fallon via email? If so, please check the box and provide your email address: <input type="checkbox"/>			Home phone
Social Security #**	Date hired (MM/DD/YYYY)	Work phone	
Race (please choose one) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other			
Work status (please choose one) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			
Average # of hours worked weekly	Department #	Employee #	
Does your spouse have health insurance from another source? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide the name of your selected primary care provider (PCP). Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First name	MI	Last name	

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Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 2: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 3: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 4: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		
Dependent 5: First name			MI	Last name (include maiden name if applicable)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to you				Social Security #**		
Primary language			Race	Birth date (MM/DD/YYYY)		
Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
First name		MI		Last name		

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.

X _____
Employee signature (REQUIRED) Print name here Date

X _____
Employer signature (REQUIRED) Print name here Date

Group name (please print) _____

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**Required for tax purposes

The Harvard Pilgrim HMO

PO BOX 9185 • QUINCY, MA 02269

1-888-333-HPHC

www.harvardpilgrim.org

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

- | | | |
|--|--|--|
| <input type="checkbox"/> ENROLLMENT | <input type="checkbox"/> CHANGE | <input type="checkbox"/> TERMINATION |
| <input type="checkbox"/> NEW HIRE | <input type="checkbox"/> CHANGE COVERAGE TYPE | <input type="checkbox"/> LEFT EMPLOYMENT |
| <input type="checkbox"/> ANNUAL OPEN ENROLLMENT | <input type="checkbox"/> ADD DEPENDENT LISTED BELOW | <input type="checkbox"/> NO LONGER ELIGIBLE |
| <input type="checkbox"/> LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS) | <input type="checkbox"/> TERMINATE DEPENDENT LISTED BELOW | <input type="checkbox"/> VOLUNTARY CANCELLATION |
| <input type="checkbox"/> P/T TO F/T DATE _____ | <input type="checkbox"/> NAME/ADDRESS CHANGE | <input type="checkbox"/> DECEASED DATE _____ |
| | <input type="checkbox"/> LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS) | <input type="checkbox"/> MOVED FROM SERVICE AREA |
| | <input type="checkbox"/> MARRIAGE DATE _____ | |
| | <input type="checkbox"/> NEWBORN DATE _____ | |

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME WSHG Town of Wellesley	DATE OF HIRE 0 1 8 9 9 2 - 0 0 1 8	EFFECTIVE DATE
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EMPLOYEE NAME FIRST _____ MIDDLE _____ LAST _____		TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 2-PERSON (ONLY WHERE OFFERED) <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER	
ADDRESS APT. NO. _____ STREET _____ PO BOX _____		PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK 02 SPOUSE 03 CHILD UNDER 19 03 CHILD TAX DEPENDENT 19-25 (MA ONLY) 03 CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY) 04 STEPCHILD UNDER 19 05* FULL-TIME STUDENT 19 AND OVER 06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE	
CITY _____ STATE _____ ZIP _____	COUNTY _____		
TELEPHONE (HOME) _____	TELEPHONE (WORK) _____	IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN. AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.	

FIRST	MI	LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?	PCP#
EMPLOYEE				- -	M F	01	- -		Y N	
SPOUSE				- -	M F		- -		Y N	
DEPENDENT				- -	M F		- -		Y N	
DEPENDENT				- -	M F		- -		Y N	
DEPENDENT				- -	M F		- -		Y N	
DEPENDENT				- -	M F		- -		Y N	

LANGUAGE CODES (OPTIONAL) WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language
 CA Cantonese
 CV Cape Verdean
 EN English
 FR French
 HA Haitian
 HM Hmong
 IT Italian
 KH Khmer
 LO Laotian
 MN Mandarin
 PT Portuguese
 RU Russian
 SP Spanish
 VI Vietnamese
 OTHER _____ Specify _____

* IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION: STUDENT(S) NAME _____ NAME OF SCHOOL(S) _____ STATE _____ _____ _____ THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY	HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE. E-MAIL ADDRESS: _____ (OPTIONAL) YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.
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MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. FOR AN EXPLANATION OF HOW HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT.
 MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.
 NEW HAMPSHIRE MEMBERS: PLEASE NOTE THAT AN ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT (N.H. RSA 420-B:8(V)(b)).
 I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE _____	DATE _____	EMPLOYER SIGNATURE _____	DATE _____
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MEMBER ENROLLMENT FORM

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

EMPLOYER SECTION

Group/Company Name _____ Group Number _____

Office Location _____ Date of Hire _____ Effective Date of Coverage _____

Type of Enrollment: New Hire Open Enrollment COBRA New Group Qualifying Event (MUST specify) _____ Qualifying Event Date _____

MEMBER SECTION PRODUCT (Select corresponding letter from the list on the front page) _____ Other _____

Last Name _____ First Name _____ Middle Initial _____ Primary Language _____

Employee Social Security Number (required) _____ - _____ - _____ Date of Birth (MM/DD/YYYY) _____ / _____ / _____ Gender: Male Female

Mailing (Home) Address _____ City _____ State _____ ZIP _____ Home Telephone (_____) _____

Marital Status: Single Married Divorced Domestic Partner Type of Coverage Requested: Individual Family Other _____ Work Telephone (_____) _____

Primary Care Provider (HMO, POS, EPO only) First Name _____ Last Name _____ PCP ID# _____ Are you an established patient of this PCP? Yes No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number	Choose a Primary Care Provider for each member (HMO, POS, EPO only. Include first and last name.)	Check if currently used for primary care	PCP ID #
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	
Child/Dependent			- -		<input type="checkbox"/>	

Please check if you are using additional membership applications for additional dependent children.

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? Yes Yes (Medicare) No

Name of Health Plan _____ Name of Plan Holder _____ Health Plan Number _____ Effective Date _____

Names of Family Members Covered _____ Is Spouse Employed? Yes No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required) _____ Date _____ Benefits Dept. Signature _____ Telephone _____ Date _____

Please Read the Instructions Before Filling Out This Form.



Enrollment and Change Form

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to 1-617-246-7531

1. To Be Filled Out by Your Employer

Company Name		Current Medical Group #:			Medical Group #, Transferring To		
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY		Date of Hire MM DD YYYY		Current Dental Group #:	Dental Group #, Transferring To	
Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER			Remarks: (i.e., qualifying event for a new add, change to family or other instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change to Family <input type="checkbox"/> New Hire <input type="checkbox"/> Add Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent				<input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other: _____

2. Yourself (Member 1)

What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> Dental Blue <input type="checkbox"/> HMO Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)	<input type="checkbox"/> Network Blue <input type="checkbox"/> PPO <input type="checkbox"/> Saver Blue	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family
Your First Name	M.I.	Last Name		Sex	Date of Birth
Street Address/ P.O. Box #		Apt. #	City/ Town	State	Zip Code
Home Phone ()		Cell Phone ()		Email	
Social Security # (REQUIRED) ¹		Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #
				Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date

3. Member 2

Please Check One: Spouse Domestic Partner Divorced Spouse (court ordered) Plan Type: Medical Dental

First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		Phone ()	Other Insurance? ¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #
				Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)		Name of PCP	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 4.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)		Name of PCP	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 5.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)		Name of PCP	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	

Please check if you are using separate forms for additional dependent children Total # of dependents: _____

5. Personal Savings Account

<input type="checkbox"/> HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
<input type="checkbox"/> FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
<input type="checkbox"/> FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: \$

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Flexible Spending Accounts – Dependent Care

Every year, you must indicate your annual allocation towards your dependent care Flexible Spending Account (FSA). The amount you elected last year will not automatically roll over.

Subscribers to a high deductible plan are only eligible to enroll in a FSA dependent care account.

You must check one of the following

I wish to CONTINUE contributions towards the FSA with the amounts indicated on the form

I wish to WAIVE this coverage

Signature

Date

Cafeteria Plan Advisors, Inc.
420 Washington St. Suite 100
Braintree, MA 02184
Phone 781.848.9848
www.CPA125.com
Fax 781.848.8477

AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

Personal Information

Name: _____ **Employer:** TOWN OF WELLESLEY

Street: _____ **Plan Year:** 7/1/19- 6/30/20

City, ST, Zip: _____ **SSN:** _____ **Date of Birth:** _____

E-Mail: _____ **Phone:** _____

Payroll Information

I am paid: Weekly: Bi-Weekly: Semi-Monthly: Monthly: Other: _____

Benefits Selected:

<input type="checkbox"/> FSA Dependent/ Day Care Account I elect to contribute \$ _____ for the Plan Year. ((\$5000 maximum) <i>Confirm eligibility criteria prior to enrolling.</i> To resume automatic Dependent Care reimbursements, a new Dependent Care Cert Form must be completed.	<input type="checkbox"/> FSA Health Care Medical Account I elect to contribute \$ <u>n/a</u> for the Plan Year. ((\$2700 maximum) <i>There is a \$500 rollover with this account.</i>
The Town of Wellesley will contribute up to \$150 for Individuals and \$450 for Families participating in the Benchmark Health Insurance plans	

Direct Deposit Information (Required if not on file with Cafeteria Plan Advisors, Inc.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account in error. I will contact Cafeteria Plan Advisors, Inc. immediately with any bank information changes.

Name of Bank: _____ **Checking** **Savings**

Check Routing Number (9 digits): _____ **Account Number:** _____

Certification

I hereby authorize a salary reduction agreement for the amount(s) shown above. I understand that:

- Cafeteria Plan Advisors, Inc. will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card (if applicable). If terminated, expenses may be incurred through termination date.
- Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- Expenses must be consistent with allowable medical deductions under IRS Publication 969.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS.
- **Current participants must re-enroll each plan year.**
- **Dependent Care Plan Participants only:** I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines (www.cpa125.com) and meet all requirements necessary to participate in the FSA Dependent Care plan. The undersigned agrees to notify the plan administrator in writing within 30 days should the undersigned no longer meet eligibility as mandated by the IRS. Dependents must qualify under IRC section 152.
- It is suggested you consult with a tax advisor since your participation will limit your ability to claim on your IRS taxes.
- If you or your spouse is 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for FSA Health Care Account.

Signature: _____ **Date:** _____

Health Savings Account

For new enrollees, please indicate the amount per calendar year you would like to contribute towards your Health Savings Account. If you already contribute to the HSA, the amount you elected will continue.

The Town will contribute \$1,000 for individuals and \$2,000 for families towards your HSA throughout the year.

You must check one of the following

I wish to CONTINUE contributions towards the HSA

I wish to WAIVE this coverage

Signature

Date

Health savings account (HSA) employee enrollment form



Return completed forms to your Human Resources Department.

Employer information
Enrollment cannot be processed without your employer's name.
Employer name

Account holder information			
First name	M.I.	Last name	
SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone ()	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

Insurance coverage	
Insurance carrier	
Coverage effective date	Coverage type <input type="checkbox"/> Single <input type="checkbox"/> Family

Authorization and certification		
<p>By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement here: http://resources.healthequity.com/Forms/Agreements/HealthEquity_Custodial_Agreement.pdf. Upon enrollment, you understand and agree to the following:</p> <ul style="list-style-type: none"> You are covered by a qualified high deductible health plan (HDHP). You are not covered by any other non-qualified health coverage, including Medicare. You are not claimed as a dependent on another individual's tax return. HealthEquity must verify your identity in order to open your HSA. <p>For further information regarding HSA laws, go to http://www.irs.gov/pub/irs-pdf/p969.pdf.</p>		
Print name	Signature	Date

Contribution information and authorization	Frequency of payroll <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
Please withhold \$_____ from my payroll and apply the funds to my HealthEquity HSA.	
Signature	Date

2018 annual HSA contributions		
Coverage type	Total annual contribution*	Per month
Self-Only	\$3,450	\$287.50
Family	\$6,900	\$575.00

2019 annual HSA contributions		
Coverage type	Total annual contribution*	Per month
Self-Only	\$3,500	\$291.66
Family	\$7,000	\$583.33

*Employer and employee contributions count towards the maximum yearly contribution amount.

Your HSA cash balance is held at an FDIC-insured or NCUA-insured institution and is eligible for federal deposit insurance, subject to applicable requirements and limitations.

Dental Insurance – Altus Dental

This year, the Town of Wellesley is switching dental insurance providers to Altus Dental.

You will automatically be enrolled in the comparable high or low plan if you are currently enrolled in dental insurance under Blue Cross Blue Shield. You do not need to make any changes if you wish for your coverage from Blue Cross Blue Shield to roll over to Altus Dental

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date

Please print.

Employer Group Name		Altus Dental Group Number		Date of Hire	Location No. (if applicable)																					
Social Security No. / Subscriber I.D. No.		Subscriber Name: First - Last																								
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.																								
Effective Date of Action:		Apt. No.	City	State	Zip																					
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member			DEPENDENT INFORMATION																							
			First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.																				
ACTION CODE (Check one. Changes must be made on the first of the month.) ADDITIONS: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement			DENTIST INFORMATION List the dentists you or your covered family members use: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Dentist(s) Last Name</th> <th style="width: 30%;">First Name</th> <th style="width: 30%;">City/Town</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Dentist(s) Last Name	First Name	City/Town																		
						Dentist(s) Last Name	First Name	City/Town																		
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student			CORRECTIONS / OTHER REMARKS _____ _____																							
						STATUS CHANGE: <input type="checkbox"/> Change "Type of Coverage" Please indicate change (e.g. Individual to Family) in the section below. <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____																				
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family		PLAN TYPE (Please check box if applicable.) <input type="checkbox"/> High Option <input type="checkbox"/> Low Option																					
COORDINATION OF BENEFITS																										
DENTAL — Are You or Any of Your Dependents Covered by <u>Another Dental Plan</u> ? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																										
Other Dental Insurance Name: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																						
Other Dental Insurance Address: _____																										
Employer Name Through Which You/Your Dependents Have Other Insurance: _____																										
Group Policy No.		Policyholder Name		Policyholder ID No.																						
MEDICAL — Are You or Any of Your Dependents Covered by <u>A Medical Plan</u> ? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																										
Name of Medical Insurance Company/HMO: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																						
Name of Health Plan/Type of Coverage: _____																										
Employer Name Through Which You/Your Dependents Have Other Insurance: _____																										
Group Policy No.		Policyholder Name		Policyholder ID No.																						

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Altus Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____

Date _____

Benefits Administrator Authorization _____

Date _____

EyeMed Vision

EyeMed provides benefits for purchasing eyeglasses and contacts. Members can realize significant savings at some of the most popular retail stores, including LensCrafters, Target Optical and Glasses.com.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date



Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.

Required sections are marked with an *.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name* / / Effective Date** / /

Group Number* Subgroup*

Location Code

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Employee Information: to be completed by Employee

Change Type*: Add Term Update Member ID:

Last Name* Date of Birth* / /

First Name* MI Gender* Male Female Phone Number () -

Street Address*

City* State* Zip Code* Social Security Number** - -

Employee Email Address:

^Last four digits of Employee's Social Security Number are required.

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 2 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 3 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 4 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Employee Signature*: _____

Date*: / /

Aflac – New \$150,000 Life Insurance Option

Aflac will be offering a brand new Group Term Life insurance product with a July 1, 2019 effective date.

- Requires NO medical check-up
- Allows employees to buy up to \$150,000, guaranteed-issue (no health questions)
- Employees can use their allowance
- Affordable rates that fit most budgets
- Convenient payroll deduction (premiums deducted right from your paycheck)

Monthly Rates			
Age	\$10,000	\$50,000	\$150,000
0 – 24	\$.69	\$3.45	\$10.35
25 – 29	\$.81	\$4.05	\$12.15
30 – 34	\$1.16	\$5.80	\$17.40
35 - 39	\$1.27	\$6.35	\$19.05
40 – 44	\$1.39	\$6.95	\$20.85
45 – 49	\$2.20	\$11.00	\$33.00
50 – 54	\$3.24	\$16.20	\$48.60
55 – 59	\$6.13	\$30.65	\$91.95
60 – 64	\$9.37	\$46.85	\$140.55
65 – 69	\$18.16	\$90.80	\$272.40
70 +	\$29.39	\$146.95	\$440.85

This new life insurance program is separate and independent from what the Town currently offers. You can still keep the current life insurance product, which is currently \$15.42 per month for \$10,000 of life insurance. There will be no changes to the old life insurance program. **We encourage all employees to compare the costs of the new program to what you are currently paying.**

You must check one of the following

I wish to ENROLL in this new policy

I wish to WAIVE this coverage

Signature

Date



CONTINENTAL AMERICAN INSURANCE COMPANY

300 Southborough Drive, Suite 200, South Portland, Maine 04106

EMPLOYEE ENROLLMENT FORM FOR GROUP LIFE , AND AD&D , AND

This Area for Agent or Plan Administrator Use Only.

Group Number(s):	Effective Date of Coverage: The first day of _____, _____ Month Year
------------------	--

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed and dated by the Applicant.

Failure to sign and date this application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Home Address Number/Street		City		State	Zip
Home Phone Number ()	Employer Name	Your Work Location/Site			
Date of Hire	Occupation	Annual Income \$	Your scheduled work hours per week		

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

- I authorize my employer's Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Continental American Insurance Company, and are to be paid to Continental American Insurance Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. To revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions. I must abide by any rules specified by the employer's benefit plan and/or by law.
- I am applying for the coverages designated for which I am eligible under my employer's plan with Continental American Insurance Company.
- All of the information on this application is complete, correct and true to the best of my knowledge and belief.
- I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is in a hospital or similar facility.
- FOR LIFE/AD&D INSURANCE:** I designate the beneficiary(ies) named in the beneficiary section of this application to receive any benefits payable in the event of my death.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided Continental American Insurance Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me. Furthermore, the insurance shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

Dated at: _____ On: _____ / _____ / _____
City State Month Day Year

Signature of Employee

Printed Name of Employee

Enroller/Agent

Agent Number

All applicants must complete this page to request coverage.

Employee Last Name	First Name	Middle Initial	Social Security No.
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Depending on the amount of coverage you elect, you and/or your spouse may be required to complete the Health Questions on page 5. Consult your agent for details.
 Life Benefit Amounts for your Spouse and Dependent Children cannot exceed 50%100% of your life insurance amount.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Total Amount Of Coverage Applied For	If (I) Or (D), My Prior Coverage Was	Rate(s)	Monthly Premium
Life Employee <input type="checkbox"/> Yes <input type="checkbox"/> No					
AD&D: Employee <input type="checkbox"/> Yes <input type="checkbox"/> No (Must be equal to amount of Employee Life Insurance election)					
Select up to \$150,000 of coverage, or a maximum of 5 times your salary, in increments of \$10,000					See Human Resources for current rates

Payroll Deduction frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	Payroll Deduction Amount: Number of Salary Deductions/Year _____	Total Monthly Premium:
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Spouse Name (last, first, middle initial)	Spouse Gender M <input type="checkbox"/> F <input type="checkbox"/>	Spouse Birth Date (MM/DD/YY)	Spouse Social Security No.
Dependent Child(ren)'s Name(s) (last, first, middle initial)		Date(s) of Birth	

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. Continental American Insurance Company or its representatives may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone number: 866-692-6901.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Continental American Insurance Company, 300 Southborough Drive, Suite 200, South Portland, ME 04106.

Life and AD&D Insurance Beneficiary Designation

Employee Last Name	First Name	Middle Initial	Social Security No.
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If your designation does not fit into one of the sections below, please contact your HR representative or Continental American Insurance Company (the "Company") for assistance. Please return your completed Beneficiary Designation form to your Agent or Employer.

Please complete only one of the four sections below and then sign and date the bottom of this page. Please read the second page and supply the information requested if you chose #1 ("Individual(s)") on this page.

<input type="checkbox"/> 1. INDIVIDUAL(S)				
PRIMARY BENEFICIARY(IES)		All beneficiaries in this section will be considered primary. Proceeds will be paid in equal shares to primary beneficiaries who survive you unless you indicate percentages. Percentages must equal 100%.		
NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				
SECONDARY BENEFICIARY(IES)		All beneficiaries in this section will be considered secondary. If no primary beneficiaries survive you, proceeds will be paid to the surviving secondary beneficiaries named in this section. Payment will be paid in equal shares unless you indicate percentages. Percentages must equal 100%.		
NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				

<input type="checkbox"/> 2. TRUSTEE UNDER TRUST AGREEMENT	
To _____	NAME OF TRUSTEE
of _____,	or successor, as trustee under a trust agreement
CITY	STATE
of _____	NAME OF SETTLOR, GRANTOR, DONOR
Dated _____, as amended.	

<input type="checkbox"/> 3. TRUSTEE UNDER WILL
To the trustee under my last will and testament, including any codicil thereto

<input type="checkbox"/> 4. ESTATE OF INSURED
To the executors or administrators of my estate

ANY AMOUNT OF INSURANCE PAYABLE AT MY DEATH SHALL BE PAYABLE AS INDICATED ABOVE

Signature _____ Date _____

LIFE and AD&D Insurance Beneficiary Designation – General Provisions

Employee Last Name	First Name	Middle Initial	Social Security No.
--------------------	------------	----------------	---------------------

- A. Please provide the name, address and telephone number of each beneficiary named in section 1 on the first page of this form.
- B. If there is no beneficiary entitled to payment in accordance with the designation, payment will be made to the spouse of the insured if living; otherwise, in equal shares to the then living children of the insured, if any; or, if none, to the father and mother of the insured, in equal shares or to the survivor of them; or, if none, to the executors or administrators of the insured's estate.
- C. Continental American Insurance Company will make payment to the trustee under the insured's last will and testament if it receives at its home office, within one year after the date of the insured's death, evidence satisfactory to it that the trustee is authorized to receive payment under applicable law. If no evidence is received within that period, payment will be made to the executors or administrators of the insured's estate.
- D. Payment to any trustee in accordance with the designation will discharge Continental American Insurance Company to the extent of such payment, and Continental American Insurance Company will not be responsible for the proper discharge of the trust or any of its terms.
- E. If any Primary or Secondary Beneficiary dies before the insured, then that beneficiary's share will be distributed equally among the other surviving beneficiaries within the same Primary or Secondary designation, unless the insured indicates otherwise in writing.

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

NOTE – If you answered “YES” to any of the Health Questions above, please provide details below. If you require additional space, please use a separate sheet of paper and attach it to this form.

Question No.	Employee or Spouse	Description of illness, injury, or pregnancy, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (<i>include zip code</i>)

If answering Health Questions, the Employee and spouse signatures isare required on page 7 of this form.

Aflac – Basic Life Insurance \$10,000

This life insurance policy has traditionally been offered by the Town of Wellesley. The basic amount is \$10,000. If you wish to cancel this policy, any additional life insurance above the \$10,000 will be cancelled as well. If you don't know if you have this life insurance policy, or how much, contact Human Resources. The FY 19 cost was \$15.42 for \$10,000 of coverage. If you wish to only cancel you supplemental life, contact Human Resources.

You must check one of the following

I wish to CONTINUE in this new policy

I wish to WAIVE this coverage

Signature

Date



CONTINENTAL AMERICAN INSURANCE COMPANY

300 Southborough Drive, Suite 200, South Portland, Maine 04106

EMPLOYEE ENROLLMENT FORM FOR GROUP LIFE , AND AD&D

This Area for Agent or Plan Administrator Use Only.

Group Number(s):	Effective Date of Coverage: The first day of _____, _____ Month Year
------------------	--

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed and dated by the Applicant.

Failure to sign and date this application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Home Address Number/Street		City	State	Zip	
Home Phone Number ()	Employer Name		Your Work Location/Site		
Date of Hire	Occupation	Annual Income \$	Your scheduled work hours per week		

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

1. I authorize my employer's Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Continental American Insurance Company, and are to be paid to Continental American Insurance Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. To revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions. I must abide by any rules specified by the employer's benefit plan and/or by law.
2. I am applying for the coverages designated for which I am eligible under my employer's plan with Continental American Insurance Company.
3. All of the information on this application is complete, correct and true to the best of my knowledge and belief.
4. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is in a hospital or similar facility.
5. **FOR LIFE/AD&D INSURANCE:** I designate the beneficiary(ies) named in the beneficiary section of this application to receive any benefits payable in the event of my death.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided Continental American Insurance Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me. Furthermore, the insurance shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

Dated at: _____ On: _____ / _____ / _____
City State Month Day Year

Signature of Employee

Enroller/Agent

Printed Name of Employee

Agent Number

All applicants must complete this page to request coverage.

Employee Last Name	First Name	Middle Initial	Social Security No.
--------------------	------------	----------------	---------------------

Depending on the amount of coverage you elect, you and/or your spouse may be required to complete the Health Questions on page 5. Consult your agent for details.
 Life Benefit Amounts for your Spouse and Dependent Children cannot exceed 50%100% of your life insurance amount.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Total Amount Of Coverage Applied For	If (I) Or (D), My Prior Coverage Was	Rate(s)	Monthly Premium
Life Employee <input type="checkbox"/> Yes <input type="checkbox"/> No		\$10,000			\$13.84
AD&D: Employee <input type="checkbox"/> Yes <input type="checkbox"/> No (Must be equal to amount of Employee Life Insurance election)					"
-					

Payroll Deduction frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	Payroll Deduction Amount: Number of Salary Deductions/Year _____	Total Monthly Premium:
--	---	------------------------

Spouse Name (last, first, middle initial)	Spouse Gender M <input type="checkbox"/> F <input type="checkbox"/>	Spouse Birth Date (MM/DD/YY)	Spouse Social Security No.
Dependent Child(ren)'s Name(s) (last, first, middle initial)		Date(s) of Birth	

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. Continental American Insurance Company or its representatives may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone number: 866-692-6901.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Continental American Insurance Company, 300 Southborough Drive, Suite 200, South Portland, ME 04106.

Life and AD&D Insurance Beneficiary Designation

Employee Last Name	First Name	Middle Initial	Social Security No.
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If your designation does not fit into one of the sections below, please contact your HR representative or Continental American Insurance Company (the "Company") for assistance. Please return your completed Beneficiary Designation form to your Agent or Employer.

Please complete only one of the four sections below and then sign and date the bottom of this page. Please read the second page and supply the information requested if you chose #1 ("Individual(s)") on this page.

<input type="checkbox"/> 1. INDIVIDUAL(S)				
PRIMARY BENEFICIARY(IES)		All beneficiaries in this section will be considered primary. Proceeds will be paid in equal shares to primary beneficiaries who survive you unless you indicate percentages. Percentages must equal 100%.		
NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				
SECONDARY BENEFICIARY(IES)		All beneficiaries in this section will be considered secondary. If no primary beneficiaries survive you, proceeds will be paid to the surviving secondary beneficiaries named in this section. Payment will be paid in equal shares unless you indicate percentages. Percentages must equal 100%.		
NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				

<input type="checkbox"/> 2. TRUSTEE UNDER TRUST AGREEMENT	
To _____	NAME OF TRUSTEE
of _____,	or successor, as trustee under a trust agreement
CITY	STATE
of _____	NAME OF SETTLOR, GRANTOR, DONOR
Dated _____, as amended.	

<input type="checkbox"/> 3. TRUSTEE UNDER WILL
To the trustee under my last will and testament, including any codicil thereto

<input type="checkbox"/> 4. ESTATE OF INSURED
To the executors or administrators of my estate

ANY AMOUNT OF INSURANCE PAYABLE AT MY DEATH SHALL BE PAYABLE AS INDICATED ABOVE

Signature _____ Date _____

LIFE and AD&D Insurance Beneficiary Designation – General Provisions

Employee Last Name	First Name	Middle Initial	Social Security No.
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- A. Please provide the name, address and telephone number of each beneficiary named in section 1 on the first page of this form.
- B. If there is no beneficiary entitled to payment in accordance with the designation, payment will be made to the spouse of the insured if living; otherwise, in equal shares to the then living children of the insured, if any; or, if none, to the father and mother of the insured, in equal shares or to the survivor of them; or, if none, to the executors or administrators of the insured's estate.
- C. Continental American Insurance Company will make payment to the trustee under the insured's last will and testament if it receives at its home office, within one year after the date of the insured's death, evidence satisfactory to it that the trustee is authorized to receive payment under applicable law. If no evidence is received within that period, payment will be made to the executors or administrators of the insured's estate.
- D. Payment to any trustee in accordance with the designation will discharge Continental American Insurance Company to the extent of such payment, and Continental American Insurance Company will not be responsible for the proper discharge of the trust or any of its terms.
- E. If any Primary or Secondary Beneficiary dies before the insured, then that beneficiary's share will be distributed equally among the other surviving beneficiaries within the same Primary or Secondary designation, unless the insured indicates otherwise in writing.

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

Name _____

Name _____

Address _____

Address _____

Telephone Number _____

Telephone Number _____

Aflac – Accident, Critical Illness, Hospital Indemnity

The following form should be used to enroll in, or make changes to the following Aflac insurance options:

Accident: Benefits are paid directly to you if you suffer an accident like a broken bone, concussion, burn, need crutches or other accident related services.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date

Critical Illness: Benefits are paid directly to you if you are diagnosed with a critical illness, such as cancer, stroke or a heart attack.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date

Hospital Indemnity: Benefits are paid directly to you if you are admitted or confined to a hospital.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

EMPLOYEE APPLICATION
Please Mail: P.O. Box 84078
Columbus, Georgia 31993
800.433.3036

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE		ID NUMBER	
Accident				
Critical Illness				
Hospital Indemnity				
Endorsement:				
EFFECTIVE DATE:				
FOR AGENT USE ONLY				
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> New Eligible	<input type="checkbox"/> Re-Submission
Deduction start date _____				

Applicant Name (First, MI, Last)		Social Security # or ID #		Gender	Date of Birth
Street Address		City		State	ZIP
Group Policyholder Town of Wellesley #24326		Class Occupation	Location	Date of Hire	
E-mail address		Hours Worked per Week	Daytime Phone No.		
Spouse's Name (if coverage is requested)			Spouse's Gender	Spouse's Date of Birth	
Beneficiary Name/Relationship (estate unless designated otherwise)					
				Applicant	Spouse
Are you actively at work?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is your spouse now disabled or unable to work?					<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

LIST ALL ELIGIBLE CHILDREN FOR WHOM YOU ARE PROPOSING COVERAGE (FROM YOUNGEST TO OLDEST):

Name	Gender	Date of Birth	Name	Gender	Date of Birth

GROUP ACCIDENT INSURANCE

New Coverage Change in Coverage

Applicant Applicant & Spouse Applicant & Children Family

Cost per pay period: \$ _____

GROUP CRITICAL ILLNESS INSURANCE Applicant Applicant and Spouse

New Coverage Change in Coverage

With Cancer: yes Non-Invasive Cancer Benefit: yes Waiver of Premium: yes

Additional Benefits Rider

Applicant Face Amount: \$	Applicant cost per pay period: \$
Spouse Face Amount: \$	Spouse cost per pay period: \$
TOTAL cost per pay period: \$	

As of the date of this Employee Application, are you or any dependents to be insured under the Critical Illness coverage covered by a Health Plan?

Yes No **If you are not covered by a Health Plan, you will not be issued this coverage.**

STATEMENT OF INSURABILITY

COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT

	Applicant	Spouse
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1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma of the skin.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

GROUP HOSPITAL INDEMNITY INSURANCE New Coverage Change in Coverage
 Applicant Applicant & Spouse Applicant & Children Family
Base Plan: Mid
 Dependent Child Rider Dependent Spouse Rider
Cost Per Pay Period: \$ _____

If NOT Guaranteed Issue, answer the following questions:

		Applicant	Spouse	Children
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	In the last 5 years, have you sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace any existing Aflac individual policy? YES NO
If **yes**, please identify which product: Critical Illness Accident Hospital Indemnity Dental Disability
- Does this coverage replace or change any existing insurance? YES NO
If **yes**, provide carrier and policy number: _____

If yes, please review and retain a copy of the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance. By signing below, I acknowledge receipt of the Replacement Notice.

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.

Critical Illness Certification:

As of the date of this Employee Application, do any proposed Insureds have in force and/or applications pending for another critical illness policy or certificate for the same critical illnesses with Aflac or a different insurer? YES NO

As of the date of this Employee Application, please list the number of critical illnesses for which any proposed Insured has coverage in force and/or the number of applications pending. _____

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

CERTIFICATION: I have read the completed Employee Application /Statement of Insurability and the statements and answers that pertain to me and my spouse and my children. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application /Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application /Statement of Insurability is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize the Group Policyholder to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

If eligible for Medicare, I acknowledge by signing below, receipt of the Guides to Health Insurance for People with Medicare.

NOTICE OF INFORMATION PRACTICES

To issue an insurance Certificate, Continental American Insurance Company may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Continental American Insurance Company may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim, or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our Home Office.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.

IMPORTANT NOTICE: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. If you are not covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act, do not submit this application.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____

Agent's Printed Name _____ Agent No. _____ State of Enrollment _____

This form is not complete unless signed and dated as indicated.

Long Term Disability

The Town of Wellesley purchases the initial long-term disability plan for all benefit eligible employees. This plan covers 40% of your monthly base pay to a maximum of \$1,250.

Employees have the option to “buy up” to 60% of their monthly base pay to a maximum benefit of \$2,500 per month or \$6,000 per month, depending on your salary. The employee would pay the difference in the cost to “buy up” from the 40% plan to the 60% plan.

Rates are dependent on your specific annual income. Please contact Human Resources for your rate.

You must check one of the following

- I wish to CONTINUE with my current election and make no changes
- I wish to MAKE CHANGES to my current election as indicated on the form
- I wish to WAIVE this coverage

Signature

Date



CONTINENTAL AMERICAN INSURANCE COMPANY

300 Southborough Drive, Suite 200, South Portland, Maine 04106

EMPLOYEE ENROLLMENT FORM FOR LONG TERM DISABILITY INSURANCE

This Area for Agent or Plan Administrator Use Only.

Group Number(s):	Effective Date of Coverage: The first day of _____, _____ Month Year
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To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed and dated by the Applicant.

Failure to sign and date this application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Home Address Number/Street		City	State	Zip	
Home Phone Number ()	Employer Name Town of Wellesley	Your Work Location/Site			
Date of Hire	Occupation	Annual Income \$	Your scheduled work hours per week		

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

- I authorize my employer's Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Continental American Insurance Company, and are to be paid to Continental American Insurance Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. To revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions. I must abide by any rules specified by the employer's benefit plan and/or by law.
- I am applying for the coverages designated for which I am eligible under my employer's plan with Continental American Insurance Company.
- All of the information on this application is complete, correct and true to the best of my knowledge and belief.
- I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is in a hospital or similar facility.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided Continental American Insurance Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me. Furthermore, the insurance shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

Dated at: _____ On: _____
City State Month Day Year

Signature of Employee

Printed Name of Employee

Enroller/Agent

Agent Number

All applicants must complete this page to request coverage.

Employee Last Name	First Name	Middle Initial	Social Security No.
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Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Total Amount Of Coverage Applied For	If (I) Or (D), My Prior Coverage Was	Rate(s)	Monthly Premium
	60%				
Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Elimination Period <u>90</u> Max. Period of Payment _____					

Payroll Deduction frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	Payroll Deduction Amount: Number of Salary Deductions/Year _____	Total Monthly Premium:
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Spouse Name (last, first, middle initial)	Spouse Gender M <input type="checkbox"/> F <input type="checkbox"/>	Spouse Birth Date (MM/DD/YY)	Spouse Social Security No.
Dependent Child(ren)'s Name(s) (last, first, middle initial)		Date(s) of Birth	

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ATTACH MARRIAGE AND/OR BIRTH CERTIFICATES TO THIS PAGE

