

*Employees: Return this completed form to your employer.
 *Employers: Log in at ppienroll.com to update member enrollment; please retain this completed form for your records. Try *Express Terminations* and *Express Compensation* to easily enter multiple updates.

Hampshire County Group Insurance Trust
ENROLLMENT/CHANGE FORM
 PPI Employer No. _____



Section 1 – Plan Options

Employer Use Only:

Payroll/Benefit Deduction Frequency: _____

Please fill in the name of your municipality below:

Employer Name _____

Select a dental plan option:

Guardian Dental – PPO \$500 Plan

Section 2 – Type of Activity

*Employer **must** complete **both** of the following if enrolling or changing coverage:

*Date of Hire or Rehire:

		-			-						
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*Effective Date of Coverage:

		-			-						
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1. ENROLL FOR COVERAGE (List all enrollees in Section 3):

- New/Rehire
- Open Enrollment
- Part-time to Full-time status
- Loss of other coverage (HIPAA Cert from prior carrier required)

Date of Loss of Coverage: _____

2. CHANGES TO COVERAGE

A. Add Dependents (List Deps in Section 3):

- Birth/Adoption
- Marriage
- Other (specify): _____

Date of Event: _____

PLEASE NOTE THE FOLLOWING:

Provider Changes after your initial election must be reported directly to the insurance carrier.

B. Other Changes (Specify on form)

- Open Enrollment Plan Change
- Name Change
- Address Change
- Beneficiary Change

3. REMOVE COVERAGE

A. Cancel Dependents (List Deps in Section 3):

- Loss of Student Status
- Divorce/Separation
- Gained Other Coverage
- Death
- Other (specify): _____

Date of Loss: _____

B. Term Employee Coverage

- Reduced Hours
- Gained Other Coverage
- Retirement
- Other (specify): _____

Date of Loss: _____

To Terminate ALL employee coverage, please use PPI's Employer Change Report.

Section 3 – Individuals Covered (A=Add C=Change R=Remove)

EMPLOYEE:

Last Name				First Name				SS#									
Home Address						City			State		Zip						
Date of Birth			/														
Date of Birth				Gender: <input type="checkbox"/> M <input type="checkbox"/> F				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other									
Job Title:																	
Phone: () -						Email:											
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

SPOUSE (SSN Required if Electing Dental):

Last Name				First Name				SS#									
Date of Birth			/														
Date of Birth				Gender: <input type="checkbox"/> M <input type="checkbox"/> F													
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD (SSN Required if Electing Dental):

Last Name				First Name				SS#									
Date of Birth			/														
Date of Birth				Gender: <input type="checkbox"/> M <input type="checkbox"/> F													
Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)																	
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD (SSN Required if Electing Dental):

Last Name				First Name				SS#									
Date of Birth			/														
Date of Birth				Gender: <input type="checkbox"/> M <input type="checkbox"/> F													
Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)																	
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

CHILD (SSN Required if Electing Dental):

Last Name				First Name				SS#									
Date of Birth			/														
Date of Birth				Gender: <input type="checkbox"/> M <input type="checkbox"/> F													
Handicapped Child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Separate form may need to be completed)																	
Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R																	

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

