

*Employees: Return this completed form to your employer. Incomplete forms will cause a delay in processing

*Employers: Log in at www.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. For assistance, please contact PPI Service Team at clientservices@ppibenefits.com or (888) 674-0046

Hampshire County Group Insurance Trust

ENROLLMENT/CHANGE FORM

PPI Employer No. _____



Section 1 – Plan Options

Employer Use Only:
 Payroll/Benefit Deduction Frequency: _____
 Department Code: Active Retirees

Please fill in the name of your municipality below:

Employer Name _____

Please select a dental plan option:

- Delta Dental Core Plan
- Delta Dental High Plan
- ~~Delta Dental PPO \$750 Plan~~

Please indicate if you would like to enroll in vision:

- MetLife Voluntary Vision

Section 2 – Type of Activity

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

*Date of Hire or Rehire:

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|

*Effective Date of Coverage:

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|

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: _____

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

EMPLOYEE (SSN Required if Electing Dental):

| | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|------------|--|--|--|-----|--|---|--|---|-------|--|-----|--|--|--|--|--|
| Last Name | | | | First Name | | | | SS# | | | | | | | | | | | | |
| Home Address | | | | | | | | | | City | | | State | | Zip | | | | | |
| 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 | | | | | | Vision: <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 | | | | | | | | | | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Dental: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> R | | | | | | Vision: <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 | | | | | | | | | | 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 | | | | | | Vision: <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 | | | | | | | | | | 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 | | | | | | Vision: <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 | | | | | | | | | | 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 | | | | | | Vision: <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

