***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. __________

PPI Benefit Solutions
ACSA Group Insurance Trust

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):

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___	
Home Address	City	State	Zip
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other	
Job Title:			
Phone: ( ) -	Email:		
Dental: ☐ A ☐ C ☐ R	Vision: ☐ A ☐ C ☐ R		

SPOUSE (SSN Required):

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ☐ M ☐ F	
Dental: ☐ A ☐ C ☐ R	Vision: ☐ A ☐ C ☐ R	

CHILD (SSN Required):

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Vision: ☐ A ☐ C ☐ R	

CHILD (SSN Required):

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Vision: ☐ A ☐ C ☐ R	

CHILD (SSN Required):

Last Name	First Name	SS# ___ ___ ___ — ___ ___ — ___ ___ ___ ___
Date of Birth __ __ / __ __ / __ __ __ __	Gender: ☐ M ☐ F	
Handicapped Child? ☐ No ☐ Yes (Separate form may need to be completed)		
Dental: ☐ A ☐ C ☐ R	Vision: ☐ A ☐ C ☐ R	

Please use a separate sheet of paper for additional dependents.

Please continue on the reverse side

Section 4 – Waiver of Coverage (Complete and sign ***ONLY*** if waiving coverage(s) for yourself and/or your dependents)

I hereby certify that I have been given an opportunity to enroll for Group Health Insurance benefits offered by my employer and have decided **NOT** to enroll in the following coverage(s):

- ☐ Dental
- ☐ Vision
- ☐ Dependent Dental
- ☐ Dependent Vision

I understand that if I delay enrolling more than 31 days after the date I could first become insured, the Dental benefits for myself and my dependents may be limited for a period time as determined by the plan rules.

_____ _____/_____/_____

Employee's Signature Date

Section 5 – Employee Signature

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted in Section 1. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer.

I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected.

Misrepresentations: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____/_____/_____

Employee's Signature Date

Section 6 – Employer Verification

Employer's Signature	Title	Date

IMPORTANT:

The benefits you have elected are provided through a group insurance policy insured by the insurance carriers listed on this form, and identified in your certificate. Billing administration services are provided to your employer by PPI Benefit Solutions, a licensed Third Party Administrator, pursuant to an agreement previously entered into by PPI and the carrier, as required by law. The carrier is responsible for eligibility and benefit determination, payment of claims, and all other administration services associated with your coverage. If you have any questions, please feel free to contact the carrier, or PPI Benefit Solutions' Client Service Center at (888-674-0046).