Health / Dental Enrollment Form

Effective for Plan Year January 1 – December 31, 2022

Massachusetts Data Privacy Laws protect information in "**red**" on this form.

To guard against violating MA Data Privacy Laws and University policy this form cannot be submitted electronically

Instructions:
Please complete all sections, as appropriate. Sign and date this form in Section 6.

1. Employee Information (please print)

Name (Last, First, M.I.) | Clark Employee ID#

Social Security # | Date of Birth:

Address | Street | City | State | Zip Code

Home Phone | Work Phone | Gender (M/F) | Marital Status

2. Health Plan Coverage (pre-tax based on a twelve (12) month withholding schedule)

Plan	Individual Bi-Weekly	Family Bi-weekly
HPHC Focus Network*	☐ **$ 58.81**	☐ **$ 248.37**
HPHC HMO*	☐ **$ 172.03**	☐ **$ 544.72**
HPHC Best Buy HMO*	☐ **$ 103.39**	☐ **$ 365.05**
HPHC PPO	☐ **$ 262.28**	☐ **$ 776.21**

*** Indicate your Primary Care Physician in Section 4 below.**

☐ **I do NOT want group health insurance; I am waiving my option for Plan Year January 1 – Dec. 31, 2022**
(**Complete Health Refusal Form in Section 5**.)

3. Dental Coverage (pre-tax based on a twelve (12) month withholding schedule)

Plan	Individual Bi-Weekly	Family Bi-weekly
BCBS Dental Blue Program 2	☐ **$ 23.71**	☐ **$ 62.80**

☐ **I do NOT want group dental insurance; I am waiving my option for Plan Year January 1 – Dec. 31, 2022**

4. REQUIRED Health and Dental Plan Information (please print)

REQUIRED

Name (Last, First, M.I.)	Date of Birth	Gender	Social Security Number	*Primary Care Physician Name	**
Employee					
Spouse					
Child					
Child					
Child					

** ✓ If a current patient

(please see reverse side)

5. Employee Group HEALTH REFUSAL Form: Effective for Plan Year January 1 – Dec. 31, 2022

(This is to be completed only if you are NOT electing group health insurance)

____
First | Middle Initial | Last

I hereby certify that I have been given an opportunity to participate in one of the group health insurance programs offered through my employer and I do not wish to participate.

I understand that I may not be allowed to participate in this benefit until the next annual enrollment unless there is a qualified change in my family status, for example: marriage, divorce, birth or adoption of a child, death of a dependent, or the termination of my spouse's employment.

____
Employee's Signature | Date

6. * * *IMPORTANT STATEMENT* * *

This election form is valid for the period of my employment. If I terminate my employment prior to the end of the health and/or dental plan, my election will be valid through the end of the corresponding pay period in which I terminate my employment.

I understand that, in the event the amount of my group health insurance changes at any time during the period covered by the election, the amount of my election to provide such coverage will change accordingly, with no further election required on my part.

I realize that I may not make a change to my benefit selections during the Plan Year unless it is a change that is necessary and appropriate due to a qualified change in my FAMILY STATUS, (e.g. marriage, divorce, birth/adoption of a child, death of a dependent, or the termination of my spouse's/domestic partner's employment).

In the event that my salary for (a) given pay period(s) falls below the total of my benefit election(s) per pay period, reallocation of my salary will be temporarily suspended. At such time that my salary once again exceeds the total of my benefit election(s) per pay period at any time during the period covered by this ENROLLMENT FORM, the terms of this election will remain in full force, and salary reallocation will resume automatically in accordance with the terms of this election. Any amounts which would have been withheld from my salary during the suspension period will be withheld subsequently, in accordance with a schedule determined by the University, during the period ending no later than 30 days following the last day of the Plan Year covered by this election.

Signature ______________________________ Date ______________________________

Return this completed form to Human Resources by mail, campus mail or fax.

DO NOT SEND THIS COMPLETED FORM BY EMAIL