

## MIT HEALTH PLAN ENROLLMENT FORM

### 1. PERSONAL INFORMATION:

Last Name	First Name	Middle Initial	Date of Birth
Office Address	MIT Extension	Employment Date	SS#/MIT ID#

### 2. HEALTH/DENTAL/VISION PLAN INFORMATION:

<b>Type of Enrollment:</b>	<b>Effective Date of Coverage:</b>
<input type="checkbox"/> Open Enrollment	Effective Date: _____
<input type="checkbox"/> New Hire/Newly Eligible	<input type="checkbox"/> Date of Hire <input type="checkbox"/> 1 <sup>st</sup> of month following hire

- Select Health Plan:**
- Traditional MIT
  - Flexible MIT
  - Network Blue New England
  - Tufts Associated
  - Blue Care Elect (Blue Cross PPO)

- Select Dental Plan:**
- MIT Comprehensive
  - MIT Basic

- Select Vision Plan:**
- Vision Plan

Covered Members (Last Name, First)	Coverage, select which benefit for each dependent.	Sex (M/F)	Date of Birth MM/DD/YY	Social Security Number or MIT ID#	Primary Care Physician Name	Primary Care Physician #
Employee	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
Spousal Equivalent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
Dependent of Spousal Equivalent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					

Please contact Benefits if you have a dependent age 25 or older who is disabled. Additional paperwork is required.

### 3. ACKNOWLEDGEMENT/SIGNATURE, I have read and understood the information on the second page of this form

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

Remarks \_\_\_\_\_

Group Numbers      Medical                                  Dental                                  Vision

Benefits Administrator Approval \_\_\_\_\_ Date \_\_\_\_\_

I have received and reviewed information about my health plan choices. I authorize MIT to take from my pay the before-tax or after-tax contributions required by my elections. I certify that the information I have provided on this form is true and correct to the best of my knowledge. I also understand if I elect before-tax payment of my health premium, I cannot change this election during the plan year unless I have a change in my personal situation that would, under federal law, permit modification of my election. I understand that the information I have provided on this form will be supplied to my health plan. With this membership, I agree that certain medical records may be required by the health plan to determine the validity or amount payable for charges related to medical care. I authorize the health plan, or its designated agent, to obtain, view, and release a copy of all records pertaining to medical care and the related expenses for all persons covered by this contract. This applies to all physicians, hospitals, clinics, and all other agencies. I grant my health plan any legal right that I may have to recover the cost of services for an illness or injury caused by someone else when these services have been provided by my health plan.

**EFFECTIVE DATES:**

• **For open enrollment**

Fill in the first day of the next year, for example, MM/DD/YYYY

• **For new hires**

Fill in either of the following dates depending on your circumstances:

– your date of employment; or

– the first day of the month following your date of employment (if you will have coverage until then)

**For Office Use Only**

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Remarks

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Group Numbers

Medical

Dental

Vision

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Benefits Administrator Approval

Date