

Delaware Valley Health Trust New Hire/Termination/Change Form

A. Employee Information-Please read, fill in the entire form and sign. Please print clearly.

Public Entity Kent County, DE	Last name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one) Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/>
Department N/A	Home Street Address		Apt #	City	State ZIP Code
Home Telephone	Work Telephone	Email address (if available)			Hours worked per week

New Hire: Effective Date _____ Hire Date _____
 Change in Coverage: Effective Date _____ **Type of Event:** _____
 Change of Address: Effective Date _____
 Name Change: Effective Date: _____ Change Name To: _____
 Termination: Effective Date _____
 Offer COBRA: Yes - COBRA Qualifying Event Date: _____
 No - Reason _____

COBRA Qualifying Event Type:
Member: Voluntary Termination Retirement Resignation Involuntary Termination (Other than Gross Misconduct) Reduction of Hours Military Leave
Dependent: Divorce or Legal Separation Dependent No Longer Eligible Death of covered member Employee Medicare Eligible (this is rare)
DEPENDENT ADDRESS: If dependent lives at a different address please note name of dependent and provide his/her address:

B. Individuals Covered - List individuals for whom you are requesting coverage/change. For additional children, please attach another sheet.

	Last name, First name, M.I.	(A)dd (C)hange (R)emove	Gender M F	Date of Birth	Social Security Number	Check if dependent is a Full-Time Student (FTS) or Dependent with a Disability (D)		HMO/QPOS Primary Care Physician Info		
								Primary Office Number (6 digits or less)	Primary Care Physician Name (Last Name, First Name)	Office Location (city &/or zip code)
Self			<input type="checkbox"/> <input type="checkbox"/>					N/A	N/A	N/A
Spouse			<input type="checkbox"/> <input type="checkbox"/>			FTS	D	N/A	N/A	N/A
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A

C. Plan Option & Coverage Level Selection -Select coverage level

Medical Plan Selection (select Open Choice PPO)	Plan co-pay High=10/25/75Rx Low=20/60/80Rx	Medical Coverage Level (select one)	Dental Coverage Level (N/A - NOT APPLICABLE)
HMO	<input type="checkbox"/>	N/A	Employee Only <input type="checkbox"/>
QPOS	<input type="checkbox"/>	N/A	Employee and Spouse <input type="checkbox"/>
Choice POS II (Open Access)	<input type="checkbox"/>	N/A	Employee and Child <input type="checkbox"/>
Open Choice PPO High or Low	<input type="checkbox"/>	Employee and Children <input type="checkbox"/>	Employee and Children <input type="checkbox"/>
Indemnity	<input type="checkbox"/>	N/A	Family <input type="checkbox"/>

E. Other Insurance Information: No Yes If yes for any family member, please provide a photocopy of insurance card

F. Employee Signature I represent that all the information supplied on this form is true and complete.

Employee Signature - Required X	Date: / /20	Employer Verification X	Date: / /20
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