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	Last name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one) Single ❑ Married ❑ Divorced/Separated ❑
Kent County, DE					

Department	Home Street Address	Apt #	City	State	ZIP Code
N/A					

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	Gender F	Date of Birth	Social Security Number	Check if dependent is a Full-Time Student (FTS) or Dependent with a Disability (D) FTS	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			❑	❑					N/A	N/A	N/A
Spouse			❑	❑					N/A	N/A	N/A
Child			❑	❑			❑	❑	N/A	N/A	N/A
Child			❑	❑			❑	❑	N/A	N/A	N/A
Child			❑	❑			❑	❑	**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	❑	N/A	Employee Only	❑	Employee Only	**N/A**	❑
QPOS	❑	N/A	Employee and Spouse	❑	Employee and Spouse	**N/A**	❑
Choice POS II (Open Access)	❑	N/A	Employee and Child	❑	Employee and Child	**N/A**	❑
Open Choice PPO High or Low	❑		Employee and Children	❑	Employee and Children	**N/A**	❑
Indemnity	❑	N/A	Family	❑	Family	**N/A**	❑

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		**Employer Verification**	
X	**Date: / /20**	**X**	**Date: / /20**