Human Resources

MIT HEALTH PLANS ENROLLMENT/CHANGE FORM

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Initial	Phone/Email	MIT ID Number	Sex	Date of Birth

2. ENROLLMENT/QUALIFYING EVENT:

☐ Open Enrollment (Effective January 1 of next year)

☐ New Hire/Newly Eligible Date of Hire/New Eligibility: _____

Choose coverage start date:
- ☐ Date of Hire/New Eligibility
- ☐ 1st of month following Date of Hire/New Eligibility

☐ Qualifying Event Date of Event: _____

- ☐ Marriage/Domestic Partnership
- ☐ Divorce/Termination of Domestic Partnership
- ☐ Birth/Adoption
- ☐ Death of Dependent
- ☐ Obtaining Other Coverage
- ☐ Loss of Other Coverage
- ☐ Change in Medicaid or SCHIP eligibility
- ☐ Other

***Required Documentation for Qualifying Events (must submit within 31 days of the event):**

- **Marriage/ Partnership:** Copy of certified marriage certificate or completed Affidavit of Domestic Partnership.
- **Divorce/Termination of Domestic Partnership:** Divorce Decree issued by the Court or Declaration of Termination of Domestic Partnership.
- **Birth/Adoption:** Copy of birth certificate or letter from the hospital, or copy of adoption/legal agreement.
- **Death of Dependent:** Copy of a certified death certificate.
- **Obtaining Other Coverage:** A document from the other employer or a HIPAA notice stating coverage effective date and names of those covered on plan, or a document from the state, Medicaid, or SCHIP administrator stating the effective date of eligibility for premium assistance.
- **Loss of Other Coverage:** A document from the other employer or a HIPAA notice stating loss of coverage effective date and lists those covered on plan, or a document from the state, Medicaid or SCHIP administrator stating the effective date for the loss of coverage.

***Please see page 3 for examples of additional required documentation.**

3. BENEFIT PLAN SELECTIONS:

Dental Plan	Individual	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Family	Terminate Coverage	**Medical Plan**	Individual	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Family	Terminate Coverage	**Vision Plan**	Individual	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Family	Terminate Coverage
Basic						BCBS PPO+ Plan						Vision Plan					
Comprehensive						BCBS High Deductible Health Plan w/HSA											

MIT Benefits
77 Massachusetts Avenue, Building NE49-5000, Cambridge, MA 02139-4307
T: 617.253.6151 | F: 617.253.2694 | Email: benefits@mit.edu
Website: hr.mit.edu/benefits

4. DEPENDENT(S) INFORMATION:

Name (Last, First, Middle)	**Sex**	**Date of Birth** (MM/DD/YYYY)	**Social Security Number**	**Medical Plan**	**Dental Plan**	**Vision Plan**
☐ **Spouse** ☐ **Partner**				☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent				☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent				☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent				☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate
Dependent				☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate	☐ Enroll ☐ Terminate

Additional dependents may be listed on a separate page. Contact MIT Benefits if you have a dependent age 26 or older who has a disability. Additional paperwork is required.

5. ACKNOWLEDGEMENT/SIGNATURE

My signature below indicates that I have read and agree to the following:

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. I understand that if I receive services out-of-network, I will be subject to pay an out-of-network deductible and co-insurance.

Employee Signature	Date

For MIT Benefits Use Only:

SAP updated by:	Date:	Comments:

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Examples of Documentation Required for Validating Dependent Eligibility in MIT Health and Dental Plans

Dependent Type	Documentation Needed
Spouse	Marriage Certificate
Partner	MIT's Affidavit of Domestic Partnership
Birth child up to age 26	Birth Certificate showing name of child and name of employee
Adopted child up to age 26	Adoption Certificate showing name of child, name of employee, and birthdate of the child
Step-child up to age 26	Birth Certificate showing name of child and spouse's/domestic partner's name AND Marriage Certificate showing employee's name and spouse's/domestic partner's name
Child up to age 26 for whom you are the Legal Guardian	Proof of Legal Guardianship AND Birth Certificate
Child with a mental or physical disability up to age 26 or older who is not able to earn his or her own living	Appropriate documentation as listed above for birth, adoption or legal guardian status AND Certification by Medical Plan
Child recognized under a Qualified Medical Child Support Order	Qualified Medical Child Support Order AND Birth Certificate
Birth child of an enrolled dependent child (as defined above)	Birth Certificate showing name of birth child and name of your enrolled dependent child
Divorced Spouse	Please contact MIT Benefits