MIT HEALTH PLANS ENROLLMENT/CHANGE FORM FOR RETIREES & SUBSCRIBERS UNDER 65

1. PERSONAL INFORMATON:

Last Name	First Name	Middle Initial	Sex	Date of Birth
Home Address	City	State	Zip Code	Telephone Number

2. REQUESTED ACTION:

☐ Open Enrollment (Effective January 1st of next year)	
☐ Enroll Effective Date of Coverage:_____	☐ Terminate Coverage Date of Termination: _____

3. MEDICAL PLAN SELECTIONS:

Medical Plan	Individual	Family	Terminate Coverage
MIT Traditional (HMO)			
MIT Choice (POS)			
Blue Care Elect (PPO)			
High Deductible Health Plan (HDHP)			

4. INFORMATION ABOUT COVERED MEMBERS:

Name (Last, First, Middle)	**Sex**	**Date of Birth**	**Medical Plan**	**Primary Care Provider Information** (for the MIT Traditional & MIT Choice Plans)
Member			☐ Enroll ☐ Terminate	Name: ID:
☐ **Spouse** ☐ **Domestic Partner**			☐ Enroll ☐ Terminate	Name: ID:
Dependent*			☐ Enroll ☐ Terminate	Name: ID:
Dependent*			☐ Enroll ☐ Terminate	Name: ID:

*Additional dependents may be attached on a separate page. Contact Benefits if you have a dependent age 26 or older who is disabled. 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 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 that I cannot change this election during the plan year unless I have a change in my personal situation that would 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 do not select a Primary Care Provider (PCP), I will be subject to out-of-network deductible and coinsurance.

Signature	Date

For Office Use Only:

System updated by:	Date:	Remarks:

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