Employee Acknowledgement:
(Employees with MMHG health insurance must sign and return to employer)

- I understand that I am required to notify my employer within thirty (30) days of the following events:

  a. marriage
  b. birth of a child
  c. adoption of a child or placement for adoption
  d. legal guardianship
  e. divorce
  f. death of a dependent
  g. dependent's loss of status as a dependent (except for turning age 26)
  h. myself, my spouse or dependent becoming eligible for Medicare and/or enrolling in Medicare
  i. divorced spouse's re-marriage
  j. change of address

Caution: Failure to notify your employer that your dependent(s) is/are no longer eligible may result in being financially responsible for any claims that were paid for an ineligible dependent. Your contract may be cancelled retroactively if you have committed fraud or misrepresented yourself and/or dependent(s).

- I understand that I may cancel health insurance for myself and/or dependent(s) voluntarily at any time with 30 days advance notice.

- If I refuse health insurance or cancel coverage I understand that I may only enroll during the next open enrollment period (effective July 1st) unless a valid qualifying event occurs.

- I have received the comparison of benefits, Summary of Benefits and Coverage (SBC) and/or other benefit plan summary information that explain my health insurance benefits, HIPAA notice of privacy practices **or** have gone online to receive this information at www.MMHG.org

Mayflower Municipal Health Group reserves the right to request additional information to support eligibility in accordance with G.L. c.32B section 6.

In order to process your Health Insurance enrollment please read this form, sign, and date. Attach this document to your completed enrollment application. Please keep a copy of this form for your records.

VISIT US ON THE WEB AT: WWW.MMHG.ORG

_____ _____
Signature (subscriber) **Date**

Print Name:_____ / Employer/Governmental Unit:_____

Email address _____ (you will receive wellness email updates with important incentive programs and your email address will not be shared with anyone)

Insurance plan selected (circle one): BCBS HP / Type of plan (circle one): IND FAM