REQUIRED SUPPORTING DOCUMENTATION FOR EMPLOYEES

Documents that you need to provide in order to have coverage with MMHG

If you are planning to cover yourself only:

- There is no supporting documentation needed but you still need to sign the employee acknowledgement and attach to enrollment application

If you are planning to cover a current and/or former spouse, you will need the following:

- If you are married – Photocopy of Certified Marriage Certificate (**church documents are not acceptable**)
- If you are divorced or legally separated the following sections of Separation Agreement are **required**:
  - Divorce Absolute Date
  - Signature Page
  - Health Insurance Provisions
  - Your Former Spouse's Last Known Address

Please note: When the employee remarries and the divorce document requires continued coverage for the former spouse, the former spouse may not continue coverage under the employee's family contract even if the employee's new spouse does not wish to be covered under the employee's group plan. The former spouse may be enrolled under an individual plan if the divorce document specifies that the employee must continue coverage for the former spouse and the employee must pays 100% of premium. In no event will coverage be available after the former spouse remarries.

If you are planning to cover dependent children, you will need the following:

- Dependent Child Coverage (New and Existing) – Photocopy of Certified Birth Certificate (must have parent/child relationship listed)
- Disabled Dependent – complete Disabled Dependent form directly with the insurance company
- Adoption – Copy of Adoption Placement Letter
  - Letter must be on Adoption Agency Letterhead and include the following:
  - Name of Adoptive Parents
  - Name of Adopted Child
  - Date Child Placed in the Home
  - **Foreign Adoptions**-if the date of placement with the adopting parent(s) is not noted in the adoption documentation from the official government papers, a copy of the child's picture passport and a page showing a Department of Homeland Security, US Customs and Border Protection date stamp are required. The letter from the licensed adoption agency must state the "date of placement for the purpose of adoption."

IMPORTANT: To ensure compliance with eligibility requirements, the enrollment of adopted children will be subject to written approval of the Blue Cross Blue Shield of Massachusetts or Harvard Pilgrim Member Underwriting Department.

- Grandchild – Photocopy of Court Guardianship Appointment
  - However, if grandchild is a dependent of a dependent, copy of grandchild's certified (Long Form) birth certificate is required.

Additional Required Documents for Retirees and notes about Obtaining Required Documentation

Reminder: Massachusetts law requires that all Medicare eligible municipal retirees enroll in Medicare parts A&B and enroll in a Medicare supplement plan in order to retain municipal health insurance coverage (MMHG). (M.G.L ch.32B, section 18a)

Additional Required Documents for Retirees:

If you and/or your spouse are on Medicare, you will need the following documentation:

- See above for spousal and dependent coverage
- Photocopy of Medicare Card (include a copy of spouse's card if applicable)

If you and/or your spouse are over age 65 and not eligible for Medicare you will need the following documentation:

- See above for spousal and dependent coverage
- Letter from Social Security stating that you and/or your spouse is/are not eligible for Medicare Part A for free.
- ***IMPORTANT: IF YOU OR SPOUSE BECOME ELIGIBLE FOR MEDICARE PART A FOR FREE YOU MUST NOTIFY YOUR EMPLOYER.**

Obtaining Required Documentation:

Documents such as marriage certificates and birth certificates can be obtained by contacting the Clerk's Office of the town in which the event occurred.

Adoption verification and grandchild verification information can be obtained by contacting the adoption agency used or the Clerk of Court's office in the town in which the event occurred.

We encourage you to contact the appropriate offices as soon as possible. There may be a waiting period to obtain information.

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