Delaware Valley Health Trust – New Hire/Termination/Change Form

Health Center of Record: ☑ DVHT Health Center (Horsham PA) ☐ Anuva Health Centers (Malvern PA and West Chester PA

A. Employee Information-Please read, fill in the entire form and sign. Please print clearly.

Employer Name	Employee Last Name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one)
The County of Elk					☐ Single ☐ Married ☐ Divorced/Separated

Department	Home Street Address	Apt #	City	Zip Code

Home Telephone	Daytime Telephone	Email address (if available)

B. Enrollment/Change/Termination. Select appropriate action and provide effective date. Complete COBRA information for terminations only.

☐ **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: ☐ Termination of active employment for reason other than gross misconduct ☐ Reduction of Hours ☐ Termination, Resignation and Other coverage

Dependent: ☐ Divorce ☐ Employee entitlement to Medicare ☐ Loss of dependent child status ☐ Death of covered employee ☐ Other Coverage

(COBRA: Provide address if Dependent address is different from employee) ______

C. Individuals Covered – List individuals for whom you are requesting coverage/changes. For additional children, please complete another form.

	Last name, First name, M.I.	Gender	Date of Birth	Social Security Number	Check if Dependent is a Full-Time Student (FTS) or Dependent with a Disability (D)	Primary Care Physician Info (HMO Plan enrollees only): Primary Office Number (6 digits or less)	Primary Care Physician Name (Last Name, First Name)	Office Location (city-state/or zip code)
Self		☐ M ☐ F				N/A	N/A	N/A
Line(s) of Coverage:	1. Medical and Rx: Add ☐ Remove ☐			2. Dental: Add ☐ Remove ☐			3. Vision: Add ☐ Remove ☐	
Spouse		☐ M ☐ F				N/A	N/A	N/A
Line(s) of Coverage:	1. Medical and Rx: Add ☐ Remove ☐			2. Dental: Add ☐ Remove ☐			3. Vision: Add ☐ Remove ☐	
Child		☐ M ☐ F			☐ FTS ☐ D	N/A	N/A	N/A
Line(s) of Coverage:	1. Medical and Rx: Add ☐ Remove ☐			2. Dental: Add ☐ Remove ☐			3. Vision: Add ☐ Remove ☐	
Child		☐ M ☐ F			☐ FTS ☐ D	N/A	N/A	N/A
Line(s) of Coverage:	1. Medical and Rx: Add ☐ Remove ☐			2. Dental: Add ☐ Remove ☐			3. Vision: Add ☐ Remove ☐	
Child		☐ M ☐ F			☐ FTS ☐ D	N/A	N/A	N/A
Line(s) of Coverage:	1. Medical and Rx: Add ☐ Remove ☐			2. Dental: Add ☐ Remove ☐			3. Vision: Add ☐ Remove ☐	

D. Medical Plan Selection – please indicate copays: **HMO** N/A **QPOS** N/A **PPO** X **Choice POS II** N/A **Indemnity** N/A

E. Other Insurance Information: ☐ No ☐ Yes. If yes for any family member, please provide a photocopy of insurance card.

F. Employee Signature REQUIRED. I represent that all the information supplied in this form is true and complete.

Employee Signature X ______ **Date** ___/___/ 20___ **HR Verification** ______ **Date** ___/___/ 20___