SUBMIT TO YOUR EMPLOYER

-Employee Acknowledgement:
(Employees/Retirees must sign and return to employer)

- I understand that I am required to notify my employer within thirty (30) days of the following events if I plan to enroll on the insurance now or in the future:

  k. Marriage
  l. Birth of a child
  m. Adoption of a child or placement for adoption/legal guardianship
  n. Divorce or Legal separation
  o. Dependent child turns age 26
  p. Death of a dependent
  q. Dependent(s) enrollment in another plan
  r. Myself, or any member on my policy becoming **eligible for Medicare** and/or enrolling in Medicare
  s. Former spouse's re-marriage-former spouse is cancelled when subscriber or former spouse gets remarried
  t. Change of address

Caution: Failure to notify your employer that your spouse/dependent(s) is/are no longer eligible may result in you being financially responsible for any claims that were paid for an ineligible member. 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 by submitting a signed application with advance notice for future effective date.

- If I decline insurance or cancel coverage I understand that I may only enroll during the next open enrollment period unless a valid qualifying event occurs. I will provide notice to my employer within 30 days of qualifying event.

- I have received the comparison of benefits, summary of benefits and coverage (SBC) and/or other benefit plan summary information that explain my 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. Failure to supply required information may result in an employee/retiree being declared ineligible.

Acceptance/Waiver of Insurance-EMPLOYER COPY

Please check off your selection:

☐ **I ACCEPT enrollment at this time** **Or** ☐ **I DECLINE enrollment at this time**

_____ _____
Signature (subscriber) **Date**

Print Name:_____ **/ Employer/Governmental Unit:**_____

Email address _____**Spouse's email address:**_____

Please provide email address for important MMHG updates including wellness emails with incentive programs. Your email address will not be sold or shared.