



EMPLOYER **CITY OF RENO** GROUP # **TMWA** EFFECTIVE DATE 01/01/2020  
 HIRE DATE \_\_\_\_\_ EMPLOYER SIGNATURE \_\_\_\_\_

**EMPLOYEE INFORMATION**

NAME (LAST)		(FIRST)	(MI)	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR PO BOX)		CITY	STATE	ZIP CODE	COUNTY
PHYSICAL ADDRESS		CITY	STATE	ZIP CODE	COUNTY
DATE OF BIRTH MO — DAY — YR	MARITAL STATUS MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/>		EMAIL ADDRESS	HOME PHONE ( ) ( )	WORK PHONE ( ) ( )

**COORDINATION OF BENEFITS**

**Complete the following for Coordination of Benefits (COB)**  
 Do you or any of your Dependents listed below have Medical/Health Insurance (including Medicare/Medicaid)?  Yes  No  
**If yes, please provide copy of insurance card front and back**

**CONTRACT TERMINATION ONLY**

COMPLETION OF THIS SECTION WILL TERMINATE COVERAGE FOR SUBSCRIBER AND ALL DEPENDENTS  
 TERMINATED  DECEASED  INELIGIBLE  
 OTHER \_\_\_\_\_

**REASON FOR MEMBER AND/OR DEPENDENT CHANGES**

New Hire  Name  Surviving Dependent  Child (check below)  
 Rehire  Address \_\_\_\_\_ Foster  
 PT/FT  Reinstate \_\_\_\_\_ Adopted  
 Transfer  COBRA \_\_\_\_\_ Grandchild  
 Retiree  Open Enrollment \_\_\_\_\_ Court Ordered  
 Other \_\_\_\_\_

**ADD / DELETE DEPENDENT**

MARRIAGE  DIVORCE  
 BIRTH/ADOPTION  LOSS OF DEPENDENT STATUS  
 LOSS OF INSURANCE  DECEASED  
 Legal documentation attached as proof of above event

**MEMBER INFORMATION - COMPLETE WITH NEW OR CHANGE INFORMATION**

ACTION	★ (LAST)	(FIRST)	(MI)	SOCIAL SECURITY NUMBER	BIRTHDAY MO.DAY.YR	SEX M/F	CIRCLE ALL THAT APPLY ★★	PRIMARY CARE PHYSICIAN ★★★
ADD <input type="checkbox"/>	EMPLOYEE						M D V	
CHANGE <input type="checkbox"/>								
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY							
ADD <input type="checkbox"/>	Spouse (must be legally married)						M D V	
CHANGE <input type="checkbox"/>								
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY							
ADD <input type="checkbox"/>	Dependent Child (Relationship)						M D V	
CHANGE <input type="checkbox"/>								
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY							
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CHANGE <input type="checkbox"/>								
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY							
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CHANGE <input type="checkbox"/>								
DELETE <input type="checkbox"/>	THIS SHADED SPACE FOR HOMETOWN HEALTH USE ONLY							

★ ATTACH LEGAL DOCUMENTATION FOR DEPENDENTS TO BE COVERED WITH DIFFERENT LAST NAMES ★★ PROOF MUST BE SUBMITTED  
 ★★★ IT IS MEMBER'S RESPONSIBILITY TO VERIFY PHYSICIAN AVAILABILITY IN THEIR AREA

**PREVIOUS COVERAGE:** If you had previous medical coverage, please supply your HIPAA Certificate of Credible Coverage

**ACKNOWLEDGEMENT OF TERMS** Employee Signature **X** \_\_\_\_\_ Date \_\_\_\_\_