COUNTY COMMISSIONERS

DIANA IREY VAUGHAN
CHAIR
LARRY MAGGI
VICE CHAIR
NICK SHERMAN

(724) 228-6724

COUNTY OF WASHINGTON

COMMONWEALTH OF PENNSYLVANIA
100 WEST BEAU STREET, SUITE 202
WASHINGTON, PA 15301

HUMAN RESOURCES
DEPARTMENT

SHELLI H. ARNOLD
DIRECTOR

(724) 228-6738
FAX: (724) 250-6570

Address Change Form

If you have moved, you will need to complete the following forms for processing with Payroll and the respective health care providers:

(1) Local Earned Income Tax Residency Certification
Form Directions:

A. Complete top portion of the form- box titled "Employee Information-Residence Location. Leave gray area blank.
B. Complete bottom portion of this form- box entitled "Certification". This will need your signature; date; phone number and email address.

(2) Highmark Change Form - **If** you have the county sponsored health care insurance, you will need to complete this form to change your address for insurance purposes.
Directions:

A. Complete top portion of the form with your name (last, first, m. i.) then indicate your social security number. On the next line, include your new street address, city, state, zip code, phone number and work phone.
B. Sign and date this form at the bottom right hand side by the "X".

(3) United Concordia Change Form- if you have the county sponsored dental insurance, you will need to complete this form to change your address for insurance purposes.
Directions:

A. Start with Section B: Employee Information. You will indicate your social security number, Your Name and New Address, including City, State and Zip Code.
B. Sign and date this form at the bottom where indicated by the "X".

Once you have completed these form(s), please forward the form(s) to the Human Resources Department. You can email, fax or return these form(s) in person or via US mail.

DCED-CLGS-05 (1-11)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
GOVERNOR'S CENTER FOR LOCAL GOVERMENT SERVICES

LOCAL EARNED INCOME TAX
RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)		School District	
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
WASHINGTON COUNTY PA			25-6001043
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
100 W BEAU ST			
SECOND LINE OF ADDRESS			
SUITE 403			
CITY	STATE	ZIP CODE	PHONE NUMBER
WASHINGTON	PA	15301	724-228-6800
MUNICIPALITY (City, Borough, Township)		School District	
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE

CERTIFICATION

SIGNATURE OF EMPLOYEE	DATE
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Select Get Local Gov Support, >Municipal Statistics

HIGHMARK. Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER CHANGE FORM

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

Employer Name: WASHINGTON COUNTY	Employer Telephone Number ( )	Association Name (if applicable)	
Group Number	Employee (Last)	(First)	(M.I.)	Member Identification Number SSN:
Effective Date of Change	Please give a brief description of the changes to be made. ADDRESS CHANGE		

COMPLETE **ONLY** THE SECTIONS THAT APPLY TO **CHANGES** IN MEMBER RECORDS.

Street Address	City	State	Zip Code	Home Phone ( )	Work Phone ( )

Hire Date	Group No.	Report Code	Change Enrollment Status to: ☐ Single ☐ Insured & Spouse/Domestic Partner ☐ Parent/Child ☐ Parent/Children ☐ Family

	Employee/Contract Holder	Spouse/Domestic Partner	Dependent	Dependent	Dependent
Type of Change	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare
Previous Identification Number					
Current Identification Number					
Previous Last Name	Last	Last	Last	Last	Last
Current Last Name	Last	Last	Last	Last	Last
First Name Middle Initial	First M.I.	First M.I.	First M.I.	First M.I.	First M.I.
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Member Status	(20) Employee	(01) ☐ Spouse (29) ☐ Domestic Partner	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)
Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Primary Care Physician Name					
Primary Care Physician Number					
Existing Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marriage Date	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year

Please check one if applicable (If additional space is required, attach a separate sheet). If you ☐, your spouse/domestic partner ☐, or dependent(s) ☐, are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier: ____

Group No: ____ Effective Date: ____

Name of Policy Holder: ____

Policy Number: ____

Relationship to Highmark Policy Holder: ____

Policy Holder Date of Birth: ____

Policy Holder Employment Status: ☐ Active ☐ Retired (Date) ____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Authorized Employer Signature ____ Date ____

X ____ Employee Signature

X ____ Date

HBCBS COPY

ENR-010 (R12-09)

UNITED CONCORDIA
America's Premier Dental Insurer

DENTAL ENROLLMENT FORM

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please complete the applicable "Type of Activity" change(s) in Section A along with the identification number and employee name in Section B and Section C for dependent changes.

SECTION A: GENERAL INFORMATION

Effective Date (mm/dd/yyyy) ___/___/_____

1. TYPE OF PROGRAM

- ☐ FFS
  (Indemnity, Active PPO, Passive PPO - Please Specify)
  - ☐ Concordia Access
  - ☐ Concordia Choice
  - ☐ Concordia Flex
  - ☐ Concordia Preferred
  - ☐ Concordia Select
  - ☐ Other _____
- ☐ DHMO (Please Specify)
  - ☐ Concordia Plus
  - ☐ Other _____

2. TYPE OF ACTIVITY

- ☐ New Enrollment
- ☐ Cancel Coverage
  - ☐ Cancel All Coverage (Employee & All Dependents)
  - ☐ Cancel Dependent(s) Only (List dependents to be cancelled)
- ☒ Change (Please Specify)
  - ☐ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ☒ Change Address
  - ☐ Reinstate Coverage
  - ☐ Change Name
  - ☐ Change Group Number
  - ☐ Change Provider
  - ☐ COBRA
  - ☐ Other _____

SECTION E: FOR EMPLOYER USE ONLY

EMPLOYER INFORMATION

Employer Name: WASHINGTON COUNTY

Group Number: _____

Sub Group: _____

UCCI Payroll Location: _____

SECTION B: EMPLOYEE INFORMATION - Please print clearly to expedite your request.

1. Identification Number (For example, Social Security Number)	2. Original Employment Date (mm/dd/yyyy)		
_____	___/___/_____		
3. Employee Name (Last, First, Middle Initial)	4. Date of Birth	5. Sex	6. Provider Number (DHMO Only)
7. Home Address	City	State	Zip Code

SECTION C: DEPENDENT INFORMATION

Please list the added/cancelled dependents in this section. For more than five dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time students age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

1. Identification Number (For example, Social Security Number)	2. Type	3. Last Name	4. First Name	5. MI	6. Sex	7. Date of Birth	8. Provider Number (DHMO Only)
_____	Spouse/Domestic Partner						
_____	Dependent (A)						
_____	Dependent (B)						
_____	Dependent (C)						
_____	Dependent (D)						
_____	Dependent (E)						

SECTION D: OTHER DENTAL COVERAGE

Do you or your dependent(s) have other Group Dental Coverage? Yes ☐ No ☐
If your answer is yes, please complete the following information.

Policy Holder	Insurance Company	Policy/Identification Number	Effective Date (mm/dd/yyyy)
			___/___/_____

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

X _____ X _____

Employee Signature Date

_____

Employer Signature Phone Number Date

5000 (07/05)