

COUNTY COMMISSIONERS

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COUNTY OF WASHINGTON
COMMONWEALTH OF PENNSYLVANIA
95 WEST BEAU STREET, SUITE 400
WASHINGTON, PA 15301

HUMAN RESOURCES
DEPARTMENT

SHELLI H. ARNOLD
DIRECTOR

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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.



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) WASHINGTON COUNTY PA			EMPLOYER FEIN 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 WASHINGTON	STATE PA	ZIP CODE 15301	PHONE NUMBER 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

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** Association Name (if applicable): _____
 Group Number: **Employee (Last)** Member Identification Number: **SSN:** _____
 Employee Telephone Number: _____

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 Family

Type of Change	Employee/Contract Holder		Spouse/Domestic Partner		Dependent		Dependent	
	Add	Change (indicate reason)	Add	Change (indicate reason)	Add	Change (indicate reason)	Add	Change (indicate reason)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Terminate <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare
Previous Identification Number	_____	_____	_____	_____	_____	_____	_____	_____
Current Identification Number	_____	_____	_____	_____	_____	_____	_____	_____
Previous Last Name	Last	Last	Last	Last	Last	Last	Last	Last
Current Last Name	First	M.I.	M.I.	Female	First	M.I.	M.I.	Female
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member Status	(20) Employee	(01) Spouse (29) Domestic Partner	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	(02) Student (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)
Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marriage Date	Month / Day / Year	Month / Day / Year	Month / Day / Year	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: _____ Health Insurance Claim Number: _____ Part A Effective Date (Mo-Day-Yr): _____
 Group No.: _____ Effective Date: _____ Name of Member: _____ First: _____ Part B Effective Date (Mo-Day-Yr): _____
 Name of Policy Holder: _____ Relationship to Highmark Policy Holder: _____ End Stage Renal Disease: _____
 Policy Number: _____ Policy Holder Date of Birth: _____ Do you have a Medicare Supplement or other coverage that complements Medicare? Yes No
 Policy Holder Employment Status: Active Retired (Date) _____

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 _____ Date

Authorized Employer Signature: _____ Date: _____

Employee Signature: _____ Date: _____

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 <input type="checkbox"/> FFS (Indemnity, Active PPO, Passive PPO - Please Specify) <input type="checkbox"/> Concordia Access <input type="checkbox"/> Concordia Choice <input type="checkbox"/> Concordia Flex <input type="checkbox"/> Concordia Preferred <input type="checkbox"/> Concordia Select <input type="checkbox"/> Other _____ <input type="checkbox"/> DHMO (Please Specify) <input type="checkbox"/> Concordia Plus <input type="checkbox"/> Other _____	2. TYPE OF ACTIVITY <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Cancel All Coverage (Employee & All Dependents) <input type="checkbox"/> Cancel Dependent(s) Only (List dependents to be cancelled) <input checked="" type="checkbox"/> Change (Please Specify) <input type="checkbox"/> Add Dependent (e.g., spouse, domestic partner, child, etc.) <input checked="" type="checkbox"/> Change Address <input type="checkbox"/> Reinstale Coverage <input type="checkbox"/> Change Name <input type="checkbox"/> Change Group Number <input type="checkbox"/> Change Provider <input type="checkbox"/> COBRA <input type="checkbox"/> 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) ____/____/____
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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