

**Employee Acknowledgement:**

**(Employees with MMHG health insurance must sign and return to employer)**

- I understand that I am required to notify my employer within thirty (30) days of the following events:
  - a. your marriage
  - b. the birth of a child
  - c. your adoption of a child or placement for adoption
  - d. legal guardianship
  - e. **your divorce**
  - f. the death of a dependent
  - g. a dependent's loss of status as a dependent (except for turning age 26)
  - h. you, your spouse or a dependent becoming eligible for Medicare and/or enrolling in Medicare
  - i. your divorced spouse's re-marriage
  - j. change of address

***Caution: Failure to notify your employer that your dependent(s) is/are no longer eligible may result in being financially responsible for any claims that were paid for an ineligible dependent. 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 with 30 days advance notice.
- If I refuse health insurance or cancel coverage I understand that I may only enroll during the next open enrollment period unless a valid qualifying event occurs.
- I have received the comparison of benefits and/or other benefit plan summary information that explain my health insurance benefits, HIPAA notice of privacy practices and new extension of dependent coverage to age 26 **or** have gone online to receive this information at [www.MMHG.org](http://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.**

**Please fill in the information below and return to your employer. Keep a copy of this form for your records.**

VISIT US ON THE WEB AT: [WWW.MMHG.ORG](http://WWW.MMHG.ORG)

\_\_\_\_\_  
Signature (subscriber)

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_ / Employer/Governmental Unit: \_\_\_\_\_

Email address \_\_\_\_\_ (you will receive wellness email updates regarding important incentive programs and your email address will not be shared with anyone)