CITY OF NEW ORLEANS HEALTHCARE PLAN ENROLLMENT FORM
(ACTIVE EMPLOYEES AND PRE-65 RETIREES)
PLEASE PRINT OR TYPE

Employee ID: _____

LAST NAME FIRST INITIAL	GENDER	BIRTHDATE (MM/DD/YYYY)	PAY GRADE:	DEPARTMENT

ADDRESS	SOCIAL SECURITY NO:	MARRIED: Y/N DATE MARRIED:	DEPARTMENT: ☐ POLICE ☐ FIRE ☐ CITY

CITY STATE ZIP CODE	PHONE NO:	ALTERNATE NO:	ACTIVE ☐ RETIREE ☐ WIDOW ☐	HIRE /RETIREMENT DATE:

DO YOU WANT TO PARTICIPATE IN THE CITY'S HEALTHCARE PLAN? YES ☐ NO ☐ IF NO, SIGN AND DATE BELOW.
WHICH PLAN WOULD YOU LIKE TO ENROLL INTO? **UHC HEALTH BASE PLAN** ☐ OR **UHC HEALTH BUY-UP PLAN** ☐
DO YOU OR YOUR DEPENDENT(S) HAVE MEDICAID OR MEDICARE YES ☐ NO ☐ PLEASE PROVIDE EFFECTIVE DATE:_____
DO YOU WANT TO COVER YOUR DEPENDENTS? YES ☐ NO ☐
IF YES, PLEASE LIST THEM BELOW. (Dependents i.e.: Spouse, Domestic Partner, Son, Daughter or Legal Custody of a child, etc.)

LAST NAME FIRST MI	GENDER	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NO.

I AUTHORIZE THE PROPER DEDUCTIONS FROM MY EARNINGS AS MY CONTRIBUTION TOWARDS THE COST OF THE CITY'S HEALTHCARE PLAN.

EMPLOYEE'S SIGNATURE _____ DATE _____

HUMAN RESOURCE APPROVAL _____ DATE _____

Office use only	Codes
Effective Date	
Termination Date	
Premium Rate	
Other:	

ADP ☐ UHC ☐ ACCESS ☐

Date Received_____

Date Processed_____

Processor_____

Revised 09/01/2022