



Welcome to the Waldwin Group!

We are excited to have you as a new member of the team and look forward to providing an exciting and challenging career with our company.

To get started we have prepared this New Hire kit that you should print, complete, and get it back to us as soon as possible.

The first page has instructions and if you run into any questions while you are completing your information, please contact our human resources department.

We will be happy to help you or direct you to the proper resource.

Welcome aboard.

Sincerely,

Linda Thourpe,  
Manager of Human Resources

**Please complete all required forms.**

**Medical Plan Enrollment Form or Waiver of Coverage (required)**

**Section 125 pre-tax deduction authorization form (required)**

**Federal –W4 (required)**

**Federal I-9 Form (required)**

**Contact Aflac Directly at 617-233-3770 (Dave Hallett) for enrollment in the following benefits:**

**Dental Insurance**

**Life Insurance**

**Disability Insurance**



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1. To Be Filled Out by Your Employer					
Company Name			Current Medical Group		Medical Group Transferring To
Current BCBS ID Number, if any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Initial Eligibility Date MM DD YYYY	Current Dental Group	Dental Group Transferring To
Type of Transaction Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> <small>(Please fill in termination code, see instructions)</small>		Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)			

2. Tell Us About Yourself (Member 1)											
What product are you selecting?		HMO Blue <input type="checkbox"/>	Network Blue <input type="checkbox"/>	Blue Choice <input type="checkbox"/>	Dental Blue <input type="checkbox"/>	HMO Blue New England <input type="checkbox"/>	Blue Choice New England <input type="checkbox"/>	PPO <input type="checkbox"/>	Other (write name of Plan) _____	Kind of Membership (Medical) Individual <input type="checkbox"/> Family <input type="checkbox"/>	Kind of Membership (Dental) Individual <input type="checkbox"/> Family <input type="checkbox"/>
Your First Name				M.I.	Last Name				Sex	Date of Birth MM DD YYYY	
Street Address / P.O. Box No.				Apt. No.	City/Town				State	Zip Code	
Social Security No.		Home Telephone No. (include area code)			Other Insurance? * Y / N	Other Insurance Company Name			City/State		
Name of PCP				City/State		PCP ID Number			Is this your current PCP? Mark X, if yes. <input type="checkbox"/>		
Are you or anyone Listed Below Covered by Medicare? * Y / N		Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD		Actively Working Y / N Retired Y / N If yes, date:			

\* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

3. Tell Us About Your Spouse (Member 2)											
Spouse's First Name				M.I.	Spouse's Last Name				Sex	Date of Birth MM DD YYYY	
Social Security No.		Home Telephone No. (include area code)			Other Insurance? * Y / N	Other Insurance Company Name			City/State		
Name of PCP				City/State		PCP ID Number			Is this your current PCP? Mark X, if yes. <input type="checkbox"/>		
Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD		Actively Working Y / N Retired Y / N If yes, date:					

4. Tell Us About Your Dependents (Members 3, 4, and 5)										
Child's First Name				M.I.	Child's Last Name				Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number			Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Child's First Name				M.I.	Child's Last Name				Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number			Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Child's First Name				M.I.	Child's Last Name				Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number			Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.

**THE COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**DIVISION OF HEALTH CARE FINANCE AND POLICY**

**Employee Health Insurance Responsibility Disclosure  
2007**

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and have declined to participate in the employer's "Section 125" health insurance purchasing arrangement.

Employer Name: The Waldwin Group  
Employer Address: 15 Allerton St.  
City/State/Zip: Boston, MA 02119

Employee First Name \_\_\_\_\_

Employee MI \_\_\_\_\_

Employee Last Name \_\_\_\_\_

Employee Social Security or Tax Identification Number \_\_\_\_\_

**Employees please check the appropriate box for each question.**

- |  |     |    |
|--|-----|----|
| 1 Did you decline your Employer-Sponsored Health Plan?   | Yes | No |
| 2 Did you decline to participate in your employer's "Section 125" health insurance purchasing arrangement? | Yes | No |
| 3 Do you have other health insurance?  | Yes | No |

**Employee Affidavit**

I hereby swear (or affirm), under penalties of perjury that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I will be responsible for the full costs of all medical treatment, and that I may forfeit all or a portion of my Massachusetts personal tax exemption and other penalties pursuant to M.G.L c. 111M.

Employee Signature \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_\_

The employer must retain this document for three(3) years and make it available to the Division of Health Care Finance and Policy upon request as required by 114.5 CMR 18.00.

DHCFP-EHIRD07

**ENROLLMENT FORM FOR SECTION 125**

**FOR**

**The Waldwin Group**

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes.

Once you have made your election, you may not change your election unless you experience a change in status. You may be able to change your benefit election when:

- You experience a change in your legal marital status;
- A child is born to you or you adopt a child; or your spouse or dependent dies;
- Your spouse either gets a job or loses a job;
- You or your spouse take or return from an unpaid leave of absence, a strike or lockout;
- Your health insurance cost or coverage changes significantly because of your spouse's employment (for example, your spouse's employer has open enrollment);
- A change in your or your spouse's work status (such as changing from part-time to full-time);
- You or your spouse's worksite changes which impacts your eligibility (such as moving out of an HMO service area);
- You, your spouse or dependent gain or lose eligibility;
- Your or your spouse's plan either adds or eliminates a benefit option;
- You, your spouse or dependent becomes entitled to Medicare or Medicaid.

Note: To be permitted, any change in election must be consistent with the status event that has occurred.

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above for the plan year. I understand this agreement will remain in effect until the end of the plan year unless one of the events listed in the **Summary Plan Description** occurs, in which case I may revoke or change this agreement as provided in the Summary Plan Description. I further understand that in the event the cost of a benefit I have selected for the plan year changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

The plan covered by this agreement is: **Health Insurance**

\_\_\_\_\_ I understand the above agreement and wish to have my deduction taken out pre-tax

\_\_\_\_\_ I would prefer to have my deduction taken out post-tax

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

