The Commonwealth of Massachusetts
DEPARTMENT OF PUBLIC HEALTH
REGISTRY OF VITAL RECORDS AND STATISTICS

CERTIFICATE OF MARRIAGE

(State file number)
Seekonk
(City or town making return)
Registered No. 63

1 Place of Marriage City or Town Seekonk
(Do not enter name of village or section of city or town)

2 Date of Marriage July 29 2022
(Month) (Day) (Year)

Intention No. 67

3 FULL NAME PARTY A John D. DiPietro	11 FULL NAME PARTY B Juliana M. Silva
3A SURNAME AFTER MARRIAGE DiPietro	11A SURNAME AFTER MARRIAGE Silva-DiPietro
4 DATE OF BIRTH February 8, 1950	5 OCCUPATION Retired
12 DATE OF BIRTH April 25, 1966	13 OCCUPATION Billing Clerk
6 RESIDENCE NO. & ST. 114 Second Street	14 RESIDENCE NO. & ST. 114 Second Street
CITY/TOWN East Providence ST. RI ZIP CODE 02914	CITY/TOWN East Providence ST. RI ZIP CODE 02914
7 NUMBER OF MARRIAGE (1st, 2nd, 3rd, etc.) 2nd	7A WIDOWED OR DIVORCED Wid
15 NUMBER OF MARRIAGE (1st, 2nd, 3rd, etc.) 2nd	15A WIDOWED OR DIVORCED Div
8 BIRTHPLACE Attleboro MA	16 BIRTHPLACE Pawtucket RI
(City or town) (State or country)	(City or town) (State or country)
9 NAME OF MOTHER/PARENT Antonetta DiPietro/Daffusco	17 NAME OF MOTHER/PARENT Maria R. Aguiar/Carvolho
10 NAME OF FATHER/PARENT John DiPietro	18 NAME OF FATHER/PARENT Manuel M. Aguiar

19 THE INTENTION OF MARRIAGE by the above-mentioned persons was duly entered by me in the records of the Community of Seekonk according to law, this 20 day of July 20 22
(Name of Community)

COURT WAIVER Issued July 29 2022 by Lorraine D. Sorel
AGE ORDER (Month) (Day) (Year) (City or Town Clerk or Registrar)

20 I HEREBY CERTIFY that I solemnized the marriage of the above-named persons at No. 380 Fall River Ave St.
(If marriage was solemnized in a church, give its NAME instead of street and number)
Seekonk on July 29 2022
(Name of city or town) (Month) (Day) (Year)

Signature Lorraine D. Sorel Justice of the Peace
(Member of the Clergy, Priest, Rabbi, Imam, or Justice of the Peace, etc.)

(Print or type name)
Address 100 Peck Street, Seekonk, MA 02771

21 Certificate recorded by city or town clerk July 29, 2022 Lorraine D. Sorel
(Month) (Day) (Year) CLERK OR REGISTRAR

22 PARTY A SEX ☒ MALE ☐ FEMALE

23 PARTY B SEX ☐ MALE ☒ FEMALE

I, the undersigned, hereby certify that I am clerk of the Town of Seekonk that as such I have custody of the vital records required by law to be kept in my office, and I do hereby certify that the above is a true copy from said records.

WITNESS my hand and the SEAL OF THE TOWN OF SEEKONK
On this Twenty-ninth Day of July, 2022

Lorraine D. Sorel
Assistant TOWN CLERK

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MIA

Enrollment and Change Form

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transfering To:
Sealcoast Water District		

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #:	Dental Group #, Transferring To
	07 (MM) 29 (DD) 2022 (YYYY)	MM DD YYYY		

Type of Transaction
- ☒ ADD
- ☐ CHANGE
- ☐ TRANSFER
- ☐ CANCEL
- Three digit termination code ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) Marriage 7/29/2022

- ☐ Open Enrollment
- ☐ New Hire
- ☐ COBRA
- Change to Family: ☒ Add Spouse ☐ Add Dependent
- ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
- ☐ Other: Change of last name

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☐ Individual ☐ 2 person ☒ Family

Membership Type (Dental) ☐ Individual ☐ 2 person ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Juliane	M	Silva - DiPietro	F	4.25.66

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
114 Second ST		E. Providence	RI	02914

Phone (401) 743-3658

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	Member Identification Number
038-36-0323	Y ☐ / N ☐		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☐ / N ☐	MM DD YYYY	MM DD YYYY	MM DD YYYY		☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Divorced Spouse (court ordered) Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth
John	D	DiPietro	M	2.8.50

Social Security # (REQUIRED)[1]	Phone	Other Insurance?[1]	Other Insurance Company Name	Member Identification Number
035-34-1380	(401) 829-2751	Y ☒ / N ☐	Medicare Complete	9413476340-00

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
# 408209	Dr. Aman Nanda	E. Prov RI	Y ☒ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☒ / N ☐	02 01 15 (MM DD YYYY)	02 01 15 (MM DD YYYY)	MM DD YYYY	2DN7-FW7-PH98	☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

4. Your Eligible Dependents (Members 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Accounts

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
☐ FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

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 understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Juliane DiPietro Date 8/24/22 Employer's Signature Elizabeth LeBlanc Date 8/24/2022

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.