Request for Enrollment Change PY 23-24

Group Name: _Helena School District 1 **Group Number:** 3000684 **Effective Date of Change:**_____

Indicate Type of Change Below: ☐ RETIREE ☐ EMPLOYEE

☐ CHANGE COVERAGE FROM PREMIUM TO STANDARD (REQUIRED TO STAY ON STANDARD PLAN FOR 2 YEARS)

☐ CHANGE COVERAGE FROM STANDARD TO PREMIUM

☐ ADD DEPENDENT ☐ DROP COVERAGE (complete waiver on back) ☐ DROP DEPENDENT (complete waiver on back)

IF THIS WILL CHANGE CURRENT TYPE OF COVERAGE TO NEW TYPE OF COVERAGE CHECK NEW TYPE OF COVERAGE:

☐ SINGLE ☐ SINGLE + SPOUSE ☐ SINGLE + DEPENDENTS ☐ SINGLE + SPOUSE + DEPENDENTS

EMPLOYEE INFORMATION (*REQUIRED*):

Employee Last Name	Employee First Name	Social Security Number		Telephone Number(s)
Address	**City**	**State**	**Zip**	**E-mail Address**

CHANGE MY ENROLLMENT AS INDICATED BELOW:

Last Name, First Name, Middle Name	Sex M/F	Social Security # (required by law)	Date of Birth MM/DD/YY	Relationship Child/Spouse	Resides With Employee YES / NO		COVERAGE Add	COVERAGE Drop

REASON FOR ADD/CHANGE (indicate below)	DATE OF EVENT			REASON FOR DROP (indicate below)	DATE OF EVENT		
Newborn DOB				**Divorce or Legal Separation (circle one)**			
Adoption (attach Proof)				**In Anticipation of Divorce**			
Marriage (date of Marriage Required)				**Ineligible Dependent Max Age DATE**			
Court Order (attach Proof)				**Ineligible Dependent Other Reason:**			
Other Reason: Loss of Other Coverage: Reason for loss of coverage_____ (You must provide a Certificate of Creditable Coverage.)				**Waiving Coverage: (You must complete the waiver on the back of this form for every covered person, including the reason.)**			

Do you have Secondary Insurance? If so, please complete this form. Other Insurance Information & Creditable Coverage Information Required (Use additional paper if necessary.)

Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage:

Type of Coverage: Medical ___ Pharmacy ___ Dental ___Vision ____ Effective Date:_____ Date Coverage will end: _____

Family covered under the other health plan: Self ___ Spouse ___ Name(s) of Child(ren): _____ _____ _____

Name, Phone Number, and Address of other insurance company: _____

Policy Holder's Name: _____ Policy Number: _____ ID #:_____

Medicare Enrollee's Name: _____ Medicare ID#: _____

Medicare Coverage: Part A – Effective Date: _____ Part B – Effective Date: _____ Part D – Effective Date: _____

Medicaid Enrollee's Name: _____ Medicaid ID#: _____ Medicaid Effective Date: _____

Court Ordered coverage for a dependent child (if applicable): Name(s) of Child(ren) _____ _____ _____

Policy Holder's Name: _____ Policy Number: _____

Type of Coverage: Medical ___ Pharmacy ___ Dental ___Vision ____ Effective Date: _____

Name, Phone Number, and Address of other insurance company: _____

Please include a copy of a Certificate of Creditable Coverage from your prior carrier showing the effective date and termination date, if applicable. *

I UNDERSTAND that providing inaccurate or incorrect information to any of the answers above may be considered health care fraud.

_____ _____

Employee Signature (required) **Date** (required)

HEALTH COVERAGE WAIVER FORM

(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)

GROUP / EMPLOYER NAME:	***GROUP NUMBER***
Helena School District #1	3000684
EMPLOYEE NAME: (LAST) , (FIRST) , (INITIAL)	**SOCIAL SECURITY NUMBER** – –

I *decline* to enroll in health coverage for:

□ Myself □ My Spouse ***Reason for waiver***: □ the existence of other coverage _____ (Plan Name)

□ My Dependent Child/Children (please list) □ other reason (explain)_____

1._____ 4._____

2._____ 5._____

3._____ 6._____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods".

EMPLOYEE'S SIGNATURE_____DATE SIGNED _____

SPOUSE'S SIGNATURE_____DATE SIGNED_____

(Spouse must sign if waiving coverage)

Statement of HIPAA Portability Rights

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of:

- The loss of eligibility for coverage under Medicaid or a state sponsored Children's Health Insurance Program (CHIP) if request for enrollment is made within 60 days after loss of such coverage: or,
- Becoming eligible for a premium subsidy from either Medicaid or CHIP for coverage under this Plan, if request for enrollment is made within 60 days after the date of the Determination Letter advising of the eligibility for the premium subsidy, issued by either Medicaid or CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.