

# Request for Enrollment Change PY 24-25

**Group Name:** Helena School District 1 **Group Number:** 3000684 **Effective Date of Change:** \_\_\_\_\_

**Indicate Type of Change Below:**                       RETIREE                                       EMPLOYEE

CHANGE COVERAGE FROM OPTION 1 TO OPTION 2

CHANGE COVERAGE FROM OPTION 2 TO OPTION 1

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 + CHILD(REN)             SINGLE + SPOUSE + CHILD(REN)

**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		COVERAGE	
					Employee YES / NO		Add	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)

<b>GROUP / EMPLOYER NAME:</b> Helena School District #1	<b>GROUP NUMBER</b> 3000684
<b>EMPLOYEE NAME: (LAST) , (FIRST) , (INITIAL)</b>	<b>SOCIAL SECURITY NUMBER</b> <p style="text-align: center;">- -</p>

**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.