Request for Enrollment Change

Group Name: CITY OF MISSOULA Group Number: 2000203 Division:______ Effective Date of Change:_________

Indicate Type of Change Below ↓

☐ NAME – If your name has changed, please indicate **YOUR PRIOR** name so we can correctly identify you:___________________________

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

☐ CHANGE BENEFICIARY ☐ NAME CHANGE

EMPLOYEE INFORMATION (REQUIRED):

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

CHANGE MY BENEFICIARY (for plans with life insurance) Use additional paper if necessary.

Last Name, First Name	Relationship	Date of Birth	Complete Address

CHANGE MY ENROLLMENT AS INDICATED BELOW:

Last Name, First Name	Sex	Social Security # (required by law)	Date of Birth	Relationship	Resides With Employee		MED		DEN		MetLife Voluntary Vision	
					YES	NO	Add	Drop	Add	Drop	Add	Drop

Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description.

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 Reason:	
Court Order (attach proof)			
Other:			
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.)	

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**
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.

EMPLOYEE'S SIGNATURE ____ DATE SIGNED _____________________

SPOUSE'S SIGNATURE ____ DATE SIGNED_____________________

(If Spouse is 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.