HEALTH BENEFIT PLAN ENROLLMENT FORM

COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW THE STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE BACK.

EMPLOYER: **JACKSON COUNTY**

MEDICAL ☐ Plan Option (if applicable) _____

EMPLOYEE NAME (FIRST) (INITIAL) (LAST)

SOCIAL SECURITY NO. (required by law) **SEX (M OR F)** **BIRTH DATE**

ADDRESS _____-_____-_____ _____ ____-____-____

CITY STATE ZIP

DATE OF HIRE ☐ Single ☐ Widowed ☐ Divorced ☐ Married

___-___-___

HOME PHONE NUMBER ( )

WORK PHONE NUMBER ( )

EMAIL ADDRESS

FOR COMPANY USE ONLY

NETWORK (based on home zip code)

☐ The Alliance/Trilogy Health Networks ☐ Cigna OAP

FOR COMPANY USE ONLY

GROUP# **DIVISION** **EFFECTIVE DATE**

DEPENDENTS (Use additional paper, if necessary)

FIRST NAME MI LAST NAME	SOCIAL SECURITY NUMBER (required by law)	BIRTH DATE	SEX	RELATIONSHIP	MEDICAL		DENTAL		VISION	
					Y	N	Y	N	Y	N

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

If dependent child is 19 or older, does he/she have medical coverage available through his/her employer? ☐ Yes ☐ No
Please note if the dependent has medical coverage available through his/her employer but did/does not elect to be covered, the answer to this question is still "yes."

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered health care fraud.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

SIGNATURE OF APPLICANT **DATE**

COMPLETE WAIVER FORM ON BACK IF YOU AND/OR YOUR DEPENDENTS CHOOSE NOT TO BE COVERED BY THIS HEALTH BENEFIT PLAN

HEALTH COVERAGE WAIVER FORM

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

COMPANY / EMPLOYER NAME:	**GROUP NUMBER**
EMPLOYEE NAME: (LAST) (FIRST) (INITIAL)	**SOCIAL SECURITY NUMBER**

I <u>decline</u> to enroll in the 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", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, as that term is defined by Federal Law (HIPAA).

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

SPOUSE'S SIGNATURE _____ DATE SIGNED _____
(If Spouse is waiving coverage)

Statement of HIPAA Portability Rights

<u>Right to get special enrollment in another plan.</u> 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 SHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

<u>Prohibition against discrimination based on a health factor.</u> 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.

OTHER HEALTH INSURANCE INFORMATION

Other Health Coverage? ☐ **Yes (complete below)** ☐ **No**
(* Please do not include coverage this plan is replacing unless you will continue to be covered under your existing plan)

Please check the coverage currently being provided elsewhere: ____ Medical ____ Dental ____Vision ____ Pharmacy
List all family members, including yourself, who are covered by other health coverage at the present time:

SELF: ☐ Yes ☐ No	**Spouse** ☐ Yes ☐ No	**Child/Children** ☐ Yes ☐ No

If you checked **YES** please list dependents below:

SPOUSE:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:

Provide name, phone number and address of your other insurance company:	Policy/Certificate Number:	Effective Date:
Policyholder's name:	Social Security Number:	Date of Birth:
If you and/or your dependents are enrolled in Medicare Part A, Part B, &/or Part D or Medicaid, please complete the following:		

Enrollee's name(s):	Medicare/Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:

Have you and/or your dependents been covered by a plan administrated by Allegiance Benefit Plan Management, Inc. in the past two years?:
☐ Yes **(complete below)**☐ No

Group Name:	Group Number: