Request for Enrollment Change

Group Name		Group Number:					Effective Date of Change:							
Indicate Type of Change Below ↓ □ NAME – If your name has changed	, please ir	ndicate YOUR	R PRIOR	name so w	e can co	orrectly id	entify y	/ou:						_
□ ADD DEPENDENT □ DROP CC	VERAGI	E (complete w	aiver on b	oack) 🗆 D	ROP D	EPENDE	NT (co	mplete		NAME V				
□ CHANGE BENEFICIARY □ NA				,			,	•			,			
EMPLOYEE INFORMATION														
Employee Last Name	(REQUI		nplovee l	First Name		Social	l Secur	ity Nu	mber	Т	elenho	one Nu	mber(s)
r v			r					.,			<u> </u>			/
Address			Ci	ty		State		Zip		E	-mail	Addre	SS	
CHANGE MY BENEFICIARY	(for plan	ns with life in	surance)	Use addit	ional p	aper if n	ecessa	rv.						
Last Name, First Name	(- 1	Relationsl		Date of Bi	-	·1		•	omplet	e Addr	ess			
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CHANGE MY ENROLLMENT	AS IND	DICATED B	ELOW:											
Last Name, First Name	Sex	Social Se	curity #	Date of			Resides With Acc		MED		DEN		V	IS
	SCA		(required by law)		Relat	tionship			Add	Add Drop		Drop	Add	
		` •	,				_ ^	loyee / NO						р
Any dependents listed above m	ust mee	t the definiti	on of a c	lependent	as list	ed in the	e Sumi	mary]	Plan D	escrip	tion.			
				-								DATE	OF EV	ENT
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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 f☐ My Dependent Child/Children (please list)		e existence of other coverageher reason (explain)	
1			_
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(If Spouse is waiving coverage)		DATE SIGNED	

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.