



MACo HEALTH CARE TRUST

ENROLLMENT & CHANGE FORM

PLEASE COMPLETE ALL SECTIONS OF THIS FORM IN BLACK INK
 INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED AND MAY DELAY ENROLLMENT
 PLEASE REVIEW THE STATEMENTS AND DISCLOSURES ON PAGE 2 OF THIS FORM

EFFECTIVE DATE OF ENROLLMENT OR CHANGE: _____

NEW ENROLLMENT OPEN ENROLLMENT
 SPECIAL ENROLLMENT – EVENT TYPE* _____
 NAME CHANGE – FORMER NAME _____
 ADDRESS CHANGE ADD/DROP DEPENDENT(S) CHANGE BASIC LIFE INSURANCE BENEFICIARY
 CHANGE TO RETIREE STATUS DROP/WAIVE COVERAGE – IF DROPPING MEDICAL, COMPLETE PAGE 2

MEMBER GROUP/ EMPLOYER NAME				GROUP NUMBER			
EMPLOYEE NAME (FIRST) ↓		(INITIAL) ↓		(LAST) ↓		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED-DATE _____ <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	
MAILING ADDRESS ↓				CITY ↓	STATE ↓	ZIP ↓	
SOCIAL SECURITY NUMBER ↓				GENDER		DATE OF BIRTH ↓	
				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
HOME/CELL PHONE NUMBER				WORK PHONE NUMBER		OCCUPATION/JOB TITLE ↓	
<input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> ELECTED OFFICIAL <input type="checkbox"/> RETIREE <input type="checkbox"/> SURVIVING DEPENDENT <input type="checkbox"/> LEAVE OF ABSENCE-START DATE _____ <input type="checkbox"/> COBRA-QUALIFYING DATE _____				HOURS WORKED / WEEK ↓			

MEDICAL PLAN SELECTION

RM500-80% RM1000-80% RM1500-80% RM2000-80% RM3000-80% NO MEDICAL COVERAGE – COMPLETE PAGE 2
 CM500-80% CM1000-80%
 HD1400-80% HD3000-80% BP2000-70%

INDIVIDUALS TO BE COVERED (ATTACH ADDITIONAL PAPER IF NECESSARY)
 ALL DEPENDENTS LISTED MUST MEET THE DEFINITION OF A DEPENDENT AS DEFINED IN THE SUMMARY PLAN DESCRIPTION

	FIRST	INITIAL	LAST	SOCIAL SECURITY NUMBER	BIRTH DATE	GENDER	MEDICAL		DENTAL		VISION	
						M/F	YES	NO	YES	NO	YES	NO
EMPLOYEE												
SPOUSE												
CHILD												
CHILD												
CHILD												

OTHER INSURANCE INFORMATION ****REQUIRED**** FAILURE TO COMPLETE THIS SECTION WILL RESULT IN THIS FORM BEING RETURNED AND WILL DELAY ENROLLMENT

DO YOU OR ANY DEPENDENTS LISTED ABOVE HAVE ANY OTHER MEDICAL INSURANCE COVERAGE? Yes No
 IF YOU ANSWER "YES", MACoHCT WILL SEND YOU A QUESTIONNAIRE TO GATHER MORE INFORMATION ABOUT THE OTHER MEDICAL INSURANCE COVERAGE SO WE CAN COORDINATE BENEFITS ON YOUR BEHALF WITH THE OTHER INSURANCE CARRIER.

BASIC LIFE INSURANCE BENEFICIARY LIFE INSURANCE POLICY INCLUDED WITH MEDICAL PLAN ENROLLMENT FOR ACTIVE ENROLLEES

PRIMARY – FULL NAME	ADDRESS	RELATIONSHIP	% OF BENEFIT
CONTINGENT – FULL NAME	ADDRESS	RELATIONSHIP	% OF BENEFIT

FOR MACoHCT USE ONLY	COMPLETED BY:	NOTES:
	DATE COMPLETED:	

*SEE PAGE 2 FOR A LIST OF SPECIAL ENROLLMENT EVENTS. DOCUMENTATION OF A SPECIAL ENROLLMENT EVENT MAY BE REQUIRED.

I UNDERSTAND THAT KNOWINGLY PROVIDING INACCURATE OR INCORRECT INFORMATION 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: _____ DATE SIGNED: _____

ENROLLMENT WAIVER FORM

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING MEDICAL COVERAGE ON THE MACoHCT PLAN

MEMBER GROUP / EMPLOYER NAME	GROUP NUMBER
EMPLOYEE NAME (FIRST) ↓ (INITIAL) ↓ (LAST) ↓	
I <u>DECLINE</u> TO ENROLL IN MEDICAL COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILD(REN)	
REASON FOR WAIVER: <input type="checkbox"/> THE EXISTENCE OF OTHER COVERAGE	
<input type="checkbox"/> OTHER REASON (EXPLAIN) _____	

I UNDERSTAND THAT THIS WAIVER OF COVERAGE MAY AFFECT THE ABILITY OF EACH PERSON NOTED ABOVE TO OBTAIN COVERAGE AT A LATER DATE EXCEPT DURING APPLICABLE 'SPECIAL ENROLLMENT EVENTS' AND 'OPEN ENROLLMENT'.

SIGNATURE: _____ DATE SIGNED: _____

SPECIAL ENROLLMENT Special Enrollment is a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage as a result of certain events that create special enrollment rights. Special enrollment events include loss of other health plan coverage. Also, in the event of marriage, birth, adoption or placement for adoption, you may enroll yourself and your newly acquired spouse and children for coverage. Coverage will become effective on the date of the event if an application for such coverage is received by the MACoHCT office within sixty (60) days of the event.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of the loss of eligibility for coverage or becoming eligible for a premium subsidy under Medicaid or a state sponsored Children's Health Insurance Program (CHIP). A request for enrollment must be submitted to the MACoHCT office within sixty (60) days of loss of such coverage or the date of the Determination Letter advising of the eligibility for premium subsidy issued by either Medicaid or CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

HIPAA PRIVACY MACoHCT is fully compliant with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

DENTAL AND VISION Coverage may be voluntarily canceled by an enrollee ONLY during the annual open enrollment period. If coverage is voluntarily canceled by an enrollee, there is a two-year waiting period before coverage can be reinstated.

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