MACo Health Care Trust

ENROLLMENT AND CHANGE FORM

TYPE OF ENROLLMENT OR CHANGE

The following grey section to be completed by county administration staff.

☐ **NEW** ENROLLMENT – DATE OF EMPLOYMENT ___/___/___ DATE OF ELIGIBILITY (MOVED FROM PT TO FT) ___/___/___	***SPECIAL ENROLLMENT EVENTS*** (MID PLAN YEAR; *DOCUMENTATION MAY BE REQUIRED*)	
☐ **OPEN** ENROLLMENT/ NEW PLAN DATE ___/___/___	☐ MARRIAGE DATE ___/___/___	☐ NEWBORN/ADOPTION DATE ___/___/___
☐ CHANGE TO **RETIREE** /DATE RETIRING ___/___/___	☐ DIVORCE DATE ___/___/___	☐ LOSS OF OTHER COVERAGE DATE ___/___/___
☐ DROP/WAIVE **EXISTING** MEDICAL COVERAGE (MID PLAN YEAR): EFFECTIVE ____/____/____ *****MUST COMPLETE MEDICAL WAIVER AT BOTTOM OF PAGE***		

NOTE: IF WAIVING **ALL** COVERAGE (OE OR NEW HIRE), COMPLETE SEPARATE WAIVER FORM

MEMBER GROUP/ EMPLOYER NAME _____**COUNTY**	**GROUP NUMBER** **640C**_____
EMPLOYEE NAME (FIRST) ⇓ **(**INITIAL) ⇓ (LAST) ⇓	☐ SINGLE ☐MARRIED ☐COMMON LAW **COMMON LAW REQUIRES AFFIDAVIT** ☐WIDOWED ☐SEPARATED
MAILING ADDRESS ⇓ **CITY** ⇓ **STATE**⇓ **ZIP** ⇓	
SOCIAL SECURITY NUMBER ⇓ **GENDER** ☐ MALE ☐ FEMALE	**DATE OF BIRTH**⇓
PHONE NUMBER ( ) **EMAIL ADDRESS**	**OCCUPATION/JOB TITLE** ⇓
☐ACTIVE EMPLOYEE ☐ELECTED OFFICIAL ☐RETIREE/UNDER 65 SPOUSE	**HOURS WORKED** ⇓ **SALARY** ⇓

MEDICAL PLAN SELECTION ☐ RM2000-80% ☐ RM3000-80% ☐ BP2000-70% ☐ HD3000-100% ☐ HD6000-100%
☐ NO MEDICAL COVERAGE – COMPLETE **ENROLLMENT WAIVER** BELOW

INDIVIDUALS TO BE COVERED - 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 M/F	MEDICAL YES	MEDICAL NO	DENTAL YES	DENTAL NO	VISION YES	VISION NO
EMPLOYEE									
SPOUSE									
CHILD									
CHILD									
CHILD									
CHILD									

☐ **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.

I DECLINE TO ENROLL IN MEDICAL COVERAGE FOR: ☐ **Self** ☐ **Spouse** ☐ **Child(ren)**

REASON FOR WAIVER: ☐ Existence of other coverage ☐ Other (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: _____

*SEE PAGE 2 FOR A LIST OF SPECIAL ENROLLMENT EVENTS. DOCUMENTION OF A SPECIAL ENROLLMENT EVENT MAY BE REQUIRED. ADD BENEFICIARY INFORMATION PAGE 2.

IF ELECTING MEDICAL COMPLETE BOTH SIDES OF FORM.

(REVISED 3/2022)

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 MACo HCT 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 MACo HCT 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 MACo HCT 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.

BASIC LIFE INSURANCE BENEFICIARY(IES): MACo HCT provided Life policy included with medical plan enrollment for active enrollees				
PRIMARY:	1	2	3	4
FULL NAME				
% OF BENEFIT				
SSN				
DATE OF BIRTH				
RELATIONSHIP				
PHONE NUMBER				
CITY/STATE				
CONTINGENT:				
FULL NAME				
% OF BENEFIT				
SSN				
DATE OF BIRTH				
RELATIONSHIP				
PHONE NUMBER				
CITY/STATE				

☐ Check if beneficiarys are the same as Basic Life

COUNTY LIFE INSURANCE BENEFICIARY(IES): County provided Life policy included for active enrollees				
PRIMARY:	1	2	3	4
FULL NAME				
% OF BENEFIT				
SSN				
DATE OF BIRTH				
RELATIONSHIP				
PHONE NUMBER				
CITY/STATE				
CONTINGENT:				
FULL NAME				
% OF BENEFIT				
SSN				
DATE OF BIRTH				
RELATIONSHIP				
PHONE NUMBER				
CITY/STATE				

☐ I decline the county paid Depedent Life (e.g. do not have a spouse or child)

DEPENDENT INFORMATION FOR COUNTY PAID LIFE				
DEPENDENTS	1	2	3	4
FIRST NAME				
LAST NAME				
SSN				
DATE OF BIRTH				
GENDER				
RELATIONSHIP				
PHONE NUMBER				
ADDRESS				
CITY/STATE				
ZIP				