



MACo HEALTH CARE TRUST

ENROLLMENT AND CHANGE FORM

TYPE OF ENROLLMENT OR CHANGE

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

<input type="checkbox"/> NEW ENROLLMENT - DATE OF EMPLOYMENT ___/___/___ DATE OF ELIGIBILITY (MOVED FROM PT TO FT) ___/___/___	<b style="color: blue;">SPECIAL ENROLLMENT EVENTS (MID PLAN YEAR; DOCUMENTATION MAY BE REQUIRED)	
<input type="checkbox"/> OPEN ENROLLMENT/ NEW PLAN DATE ___/___/___	<input type="checkbox"/> MARRIAGE DATE ___/___/___	<input type="checkbox"/> NEWBORN/ADOPTION DATE ___/___/___
<input type="checkbox"/> CHANGE TO RETIREE /DATE RETIRING ___/___/___	<input type="checkbox"/> DIVORCE DATE ___/___/___	<input type="checkbox"/> LOSS OF OTHER COVERAGE DATE ___/___/___
<input type="checkbox"/> 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) ↓ _____	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON LAW COMMON LAW REQUIRES AFFIDAVIT <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	
MAILING ADDRESS ↓ _____	CITY ↓ _____	STATE ↓ _____ ZIP ↓ _____
SOCIAL SECURITY NUMBER ↓ _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH ↓ _____
PHONE NUMBER () _____	EMAIL ADDRESS _____	OCCUPATION/JOB TITLE ↓ _____
<input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> ELECTED OFFICIAL <input type="checkbox"/> RETIREE/UNDER 65 SPOUSE		HOURS WORKED ↓ _____ SALARY ↓ _____

MEDICAL PLAN SELECTION RM1000-80% RM2000-80% BP2000-70% HD3000-100%
 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	MEDICAL		DENTAL		VISION	
							M/F	YES	NO	YES	NO	YES
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. DOCUMENTATION OF A SPECIAL ENROLLMENT EVENT MAY BE REQUIRED. ADD BENEFICIARY INFORMATION PAGE 2.

IF ELECTING MEDICAL COMPLETE BOTH SIDES OF FORM.

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				

MACo Health Care Trust
2717 Skyway Drive - Suite D, Helena MT 59602
Office: 406-443-8102 Fax: 406-443-8103