Request for Enrollment Change

Group Name: COLLIER COUNTY Group Number: 2003021 Division:_____ Effective Date of Change:_____

Indicate Type of Change Below ↓

☐ NAME – If your name has changed, please indicate **YOUR PRIOR** name so we can correctly identify you:_____
(NAME WAS)

☐ ADD DEPENDENT ☐ DROP COVERAGE (complete waiver on back) ☐ DROP DEPENDENT (complete waiver on back)

☐ CHANGE BENEFICIARY ☐ NAME CHANGE

EMPLOYEE INFORMATION (REQUIRED):

Employee Last Name	Employee First Name	Social Security Number		Telephone Number(s)
Address	**City**	**State**	**Zip**	**E-mail Address**

CHANGE MY BENEFICIARY (for plans with life insurance) Use additional paper if necessary.

Last Name, First Name	Relationship	Date of Birth	Complete Address

CHANGE MY ENROLLMENT AS INDICATED BELOW:

Last Name, First Name	Sex	Social Security # (required by law)	Date of Birth	Relationship	Resides With Employee YES / NO		MED Add	MED Drop	DEN Add	DEN Drop	VIS Add	VIS Drop
					☐	☐	☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐	☐	☐

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

REASON FOR ADD/CHANGE (indicate below)	DATE OF EVENT			REASON FOR DROP (indicate below)	DATE OF EVENT		
Newborn DOB				**Child Eligible for own Employer's Health Plan**			
Adoption (attach proof)				**Divorce or Legal Separation (circle one)** ☐ ☐			
Marriage (date of Marriage required)				**In Anticipation of Divorce**			
Court Order (attach proof)				**Ineligible Dependent**			
Other: _____				**Reason: _____**			
Loss of Other Coverage: **Reason for loss of coverage_____** **(You must provide a Certificate of Creditable Coverage.)**				**Waiving Coverage: (You must complete the waiver on the back of this form for every covered person, including the reason.)**			

Other Insurance Information & Creditable Coverage Information Required (Use additional paper if necessary.)

Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage:
Type of Coverage: Medical ☐ Pharmacy ☐ Dental ☐ Vision ☐ Effective Date:_____ Date Coverage will end: _____
Family covered under the other health plan: Self ☐ Spouse ☐ Name(s) of Child(ren): _____ _____ _____
Name, Phone Number, and Address of other insurance company: _____
Policy Holder's Name: _____ Policy Number: _____ ID #:_____
Medicare Enrollee's Name: _____ Medicare ID#: _____
Medicare Coverage: Part A – Effective Date: _____ Part B – Effective Date: _____ Part D – Effective Date: _____
Medicaid Enrollee's Name: _____ Medicaid ID#: _____ Medicaid Effective Date: _____
Court Ordered coverage for a dependent child (if applicable): Name(s) of Child(ren) _____ _____ _____
Policy Holder's Name: _____ Policy Number: _____
Type of Coverage: Medical ☐ Pharmacy ☐ Dental ☐ Vision ☐ Effective Date: _____
Name, Phone Number, and Address of other insurance company: _____

Please include a copy of a Certificate of Creditable Coverage from your prior carrier showing the effective date and termination date, if applicable. *

I UNDERSTAND that providing inaccurate or incorrect information to any of the answers above may be considered health care fraud.

_____ _____

Employee Signature (required) **Date** (required)

HEALTH COVERAGE WAIVER FORM

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

GROUP / EMPLOYER NAME: **COLLIER COUNTY**	**GROUP NUMBER** **2003021**
EMPLOYEE NAME: (LAST) (FIRST) (INITIAL)	**SOCIAL SECURITY NUMBER**

I decline to enroll in 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

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee.) Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a covered person who is less than nineteen (19) years of age.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

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.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.