# 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) ⇓ | ☐ SINGLE ☐ MARRIED-DATE_____ ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED |
| **MAILING ADDRESS** ⇓ **CITY** ⇓ **STATE** ⇓ **ZIP** ⇓ | **DATE OF BIRTH** ⇓ |
| **SOCIAL SECURITY NUMBER** ⇓ **GENDER** ☐ MALE ☐ FEMALE | **DATE OF HIRE/ELIGIBILITY** ⇓ |
| **HOME PHONE NUMBER** ( ) **WORK PHONE NUMBER** ( ) | **OCCUPATION/JOB TITLE** ⇓ |
| ☐ ACTIVE EMPLOYEE ☐ ELECTED OFFICIAL ☐ RETIREE ☐ SURVIVING DEPENDENT ☐ LEAVE OF ABSENCE-START DATE_____ ☐ 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% ☐ CM5000-80% ☐ BP2000-70%

☐ HD1400-80% ☐ HD3000-80

**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 M/F | MEDICAL YES | MEDICAL NO | DENTAL YES | DENTAL NO | VISION YES | VISION 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:** **DATE COMPLETED:** | **NOTES:** |
|---|---|---|

*SEE PAGE 2 FOR A LIST OF SPECIAL ENROLLMENT EVENTS. DOCUMENTION 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: _____



(REVISED 4/2014)

# 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 DECLINE TO ENROLL IN MEDICAL COVERAGE FOR:** ☐ MYSELF ☐ MY SPOUSE ☐ MY CHILD(REN)

**REASON FOR WAIVER:** ☐ THE EXISTENCE OF OTHER COVERAGE

☐ 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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