

# CHANGE FORM for 2010



For MACoHCT USE ONLY: Date Entered \_\_\_/\_\_\_/\_\_\_  
Notes: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group Number #: \_\_\_\_\_

**Indicate Type of Change Below ↓**

**Effective Date of This Change:** \_\_\_\_\_

NAME – Please indicate YOUR PRIOR name so we can correctly identify you: \_\_\_\_\_  
(NAME WAS)

ADDRESS CHANGE     ADD COVERAGE     ADD DEPENDENT     DROP COVERAGE     DROP DEPENDENT

STATUS CHANGED TO RETIRED     CHANGE OF BENEFICIARY     PLAN CHANGE W/ SPECIAL ENROLLMENT

**EMPLOYEE INFORMATION (REQUIRED):**

Employee First Name, Middle Initial	Employee Last Name			Social Security Number	
Address	City	State	Zip	Telephone	

**CHANGE MY ENROLLMENT AS INDICATED BELOW :**

First Name, Last Name	Sex	Social Security #	Date of Birth	Relationship	*IRS Tax Dependent Yes or No	Medical		Dental		Vision	
						Add	Drop	Add	Drop	Add	Drop

\*Please review the Senate Bill 419 and Possible Tax Consequences Form.

**CHANGE OF BENEFICIARY**

Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**REASON FOR ADD/CHANGE (indicate below)    DATE OF EVENT    REASON FOR DROP (indicate below)    DATE OF EVENT**

Newborn			Divorce or Legal Separation			
Adoption / Court Order (attach proof)			Ineligible Dependent <b>Reason:</b> _____			
Marriage (date of marriage required)			Waiving Health Benefit (Complete waiver form on the back)			
Retired: (You must provide documentation that you are eligible for retirement)			Death			
Loss of Other Coverage (You must provide a Certificate of Creditable Coverage)			Other:			

**Plan Change:**

From: \_\_\_\_\_  
(Old Plan Name) to \_\_\_\_\_  
(New Plan Name)

Note: Plan Changes only apply to Special Enrollment Events

**\*Retiree must complete for Life Insurance**     YES, I wish to continue my life insurance  
 NO, I do not wish to continue my life insurance

**REQUIRED OTHER INSURANCE INFORMATION:** Do you, your spouse or your children have other medical, dental or vision insurance?  YES     NO    If you answered yes, please provide the required information below.

SELF: <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER NAME, INSURANCE CARRIER NAME & ADDRESS	TYPE OF COVERAGE		
SPOUSE: <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED	<input type="checkbox"/> DEN	<input type="checkbox"/> VIS
CHILDREN (LIST) <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MED	<input type="checkbox"/> DEN	<input type="checkbox"/> VIS
		<input type="checkbox"/> MED	<input type="checkbox"/> DEN	<input type="checkbox"/> VIS
		<input type="checkbox"/> MED	<input type="checkbox"/> DEN	<input type="checkbox"/> VIS

\_\_\_\_\_  
**Employee Signature** (required)

\_\_\_\_\_  
**Date** (required)

**HEALTH COVERAGE WAIVER FORM**

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

Group Name			Group Number
Employee Name (FIRST)	(LAST)	(MI)	Social Security Number
I decline to enroll with MACoHCT coverage for: <input type="checkbox"/> Myself Reason for waiver: <input type="checkbox"/> the existence of other coverage <input type="checkbox"/> My Dependent Family Members: <input type="checkbox"/> other reason (explain) _____ 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 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 below. <b>I am also waiving the Basic Standard Life Insurance offered with the plan.</b> This does not include employees provided Medical coverage under their spouse's MACoHCT benefits.			

SIGNATURE OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_

**NOTICES**

**Special Enrollment Periods.** If you are waiving coverage for yourself or your eligible dependents as defined by your Plan (including your spouse) because you or they are currently covered under other health insurance or another health care plan, you may be able to enroll yourself or your dependents for coverage under this plan in the future, provided that you request such coverage within thirty (30) days after such other coverage ends. Also, if you acquire an eligible dependent, as defined by your Plan, as a result of marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll yourself and your newly acquired dependent children or spouse for coverage under this Plan, provided that you request such coverage within thirty (30) days after marriage, birth, adoption or placement for adoption. An application for coverage must be received in the MACoHCT office within 60 days of the event. Please refer to your Summary Plan Description for more detailed information.

**Pre-existing Condition Exclusion.** This health benefit plan may exclude certain medical conditions (either physical or mental) from coverage, if you or an eligible dependent received medical advice, diagnosis, treatment or care for that condition, including prescription medication, within a six (6) month period immediately preceding your enrollment date under this health benefit plan. The enrollment date means the date you or your dependent becomes eligible for coverage under this Plan. The plan will only apply the exclusion to Late Enrollees.

Such pre-existing conditions may be excluded from coverage for a period of eighteen (18) consecutive months beginning on your enrollment date.

**For information specifying the exact time periods referred to in this notice, consult your Plan Administrator, employer, or Summary Plan Description.**

**Creditable Coverage.** You or your eligible dependent, as defined by this Plan, may submit to the Plan Administrator, certification of Creditable Coverage from any prior health insurance or health care plan under which you or your eligible dependent had coverage, for the purpose of reducing, on a day-for-day basis, the pre-existing condition exclusion imposed by this Plan for any pre-existing condition for which you or your eligible dependent had applicable Creditable Coverage.

You or your eligible dependent have a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which you or your eligible dependent had coverage.

If you are unable to obtain a Certificate of Creditable Coverage from your prior insurance carrier or health plan, the Plan Administrator will provide assistance to obtain the same from your prior carrier or health plan. The Plan also has written procedures to determine Creditable Coverage if you are unable to obtain a Certificate of Creditable Coverage. Please consult the Plan Administrator for more information regarding this procedure.

"Creditable Coverage" means health or medical coverage under which you or your eligible dependent was covered, prior to your enrollment date under this Plan, which prior coverage was under any of the following:

- 1. A group health Plan
- 2. Health insurance coverage
- 3. Part A or Part B of Title XVII of the Social Security Act
- 4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928
- 5. Chapter 55 of Title 10, United States Code
- 6. A medical care program of the Indian Health Service or a tribal organization
- 7. A state health benefits risk pool
- 8. A health plan offered under Chapter 89 of Title 8, United States Code.
- 9. A public health plan including a nationalized health plan of a foreign country
- 10. A health benefit plan under Section 5(e) of the Peace Corps Act
- 11. State Children's Health Insurance Program

Creditable Coverage for which there has not been a break exceeding sixty-three (63) days prior to a Covered Person's effective date of coverage under this Plan, shall be credited on a day-for-day basis against any pre-existing condition exclusion imposed by the terms of this Plan provided that the prior creditable coverage included coverage for the excluded condition. A "Certificate of Creditable Coverage" must include the following information in order for us to determine the exact number of days to be reduced from the **pre-existing condition exclusionary period.**

- 1. The name or names of the individuals who were previously covered.
- 2. The date the previous health coverage began.
- 3. The date the previous health coverage ended.

**INSURANCE ID CARDS AND OTHER LIKE DOCUMENTS CANNOT BE ACCEPTED IN LIEU OF CERTIFICATES OF CREDITABLE COVERAGE BUT MAY BE USED AS EVIDENCE OF ANY PRIOR COVERAGE.**

**All questions about the Pre-existing condition Exclusion and Certificate Coverage should be directed to a MACoHCT ENROLLMENT SPECIALIST, 2717 Skyway Drive, Suite D, Helena, MT 59602, 1-866-669-6428.**