REQUEST FOR ENROLLMENT CHANGE FORM

Group Name_____ Group Number: _____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	
Address	**City**	**State**	**Zip**	**Telephone**

CHANGE MY BENEFICIARY (for plans with life insurance) Attach a separate sheet, if necessary:

Last Name, First Name	Relationship	Date of Birth	Complete Address / Phone Number

CHANGE MY ENROLLMENT AS INDICATED BELOW (PLEASE COMPLETE ENTIRE SECTION):

Last Name, First Name, Initial	Sex	Social Security Number (required by law)	Date of Birth	Relationship	ADD	DROP

Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description.
If a dependent child is 18 or older, is he/she eligible for group health coverage through his/her own employer? □ Yes □ No.
Is he/she entitled to benefits under Medicare? □ Yes □ No

REASON FOR ADD/CHANGE (indicate below)	DATE OF EVENT			REASON FOR DROP (indicate below)	DATE OF EVENT		
Newborn DOB				**Marriage of Dependent Child**			
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 Certificate of Creditable Coverage.)				**Waiving Coverage: (You must complete the wavier on the back of this form for every covered person, including the reason.)**			

Other Insurance Information & Creditable Coverage Information Required:

Do you or your enrolled family members have any OTHER coverage that you will keep in addition to this coverage? ___YES___ NO
*** IF YES**, please give name of each person covered, the other Plan Name, Address and Phone Number:_____
Please include a copy of your Certificate of Creditable Coverage from your prior employer/carrier showing the effective date and termination date, if applicable. *

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on this Enrollment Form may be considered health care fraud.

I ACKNOWLEDGE receipt of the HIPAA Portability Rights statement furnished to me with this form.

_____ _____

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

HEALTH COVERAGE WAIVER FORM

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

GROUP / EMPLOYER NAME:	**GROUP NUMBER**
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

□ 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 [12 months for Oregon domiciled employers, 3 months for Washington domiciled employers with 51 or more employees, 9 months for Washington domiciled employers with less than 51 employees] 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)