MMIA MONTANA MUNICIPAL INTERLOCAL AUTHORITY — EMPLOYEE BENEFITS

Benefit Enrollment, Termination or Change Form

(Fillable form available at www.mmiaeb.net/forms)

Employees: Return form to your city/town benefit administrator.

Benefit Administrator: Please fax to: 406-449-7440 or mail to MMIA at PO Box 6669 ~ Helena, MT 59604-6669

This form must be completed and returned within 31 days of the Initial Hire Date or Qualifying Event Date

Please print clearly on entire form.

Last Name	First Name	Initial	Work Phone	Home Phone	Cell Phone

Current Mailing Address	City	State	Zip

Employee's Email Address:

Employer — Group Number:

If your employer does not offer Group Life and you are waiving coverage, stop here and proceed to the back side of this form

SECTION 1 ~ Please fill out the section below that applies to a new enrollment, enrollment changes or termination of coverage

Part A - New Enrollment *(includes employees waiving coverage, but the city offers Group Life coverage)*

Effective Date of Coverage is determined by your Group Election Form for the current plan year

First Day of Work: _____

Hours worked per week: _____

Plan Status: ☐ Active Employee ☐ Retiree ☐ Elected Official ☐ Surviving Spouse

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Medical Plan Choice - Please check only one appropriate box below:

☐ Bridger ☐ Madison ☐ Mission ☐ HDHP ☐ Custom

Part B - Enrollment Changes

	Event Date
Add/Drop spouse or dependent (Open enrollment & Qualifying Event Only)	
Medicare eligible (provide copy of card or letter)	
Retiree Status	
Death	
Other (reason):	
Ineligible Dependent (reason):	
Address Change (former address):	
Name Change (former name):	

Part C - Termination of Coverage ***If staying on coverage as a retiree see Part B***

Date Employment Terminated _____ If still employed or retired, date ending coverage

☐ Voluntary by employee ☐ Involuntary by employer

Type of Qualifying Event (Term, Resignation, Reduce Hrs, Death): _____

*****Coverage will end the last day of the month in which employee was terminated.*****

Medical Plan Choice - Open Enrollment & Qualifying Events Only

☐ Bridger ☐ Madison ☐ Mission ☐ HDHP ☐ Custom (if applicable)

Must provide supporting legal documentation of divorce, marriage, adoption, etc. with this form

Notes: Use this space for clarification on any of the above

SECTION 2 ~ INDICATE ENROLLMENT REQUESTS BY CHECKING ONLY BOXES THAT APPLY TO CURRENT CHANGE(S) OR NEW ENROLLMENT ***Note: Your group may not offer all coverages listed***

FIRST MI LAST *New enrollee - must complete employee info also*	SOCIAL SECURITY # (Required)	DATE OF BIRTH	RELATIONSHIP	Sex	Medical		Dental		Vision		Group Life		Vol Life	
					Add	Drop	Add	Drop	Add	Drop	Add	Drop	Add	Drop
Employee:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spouse:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child(ren): (list)					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

NOTE: IF YOU OR YOUR DEPENDENTS ARE ENROLLING DUE TO A LOSS OF OTHER COVERAGE, PLEASE ATTACH VERIFICATION OF CREDITABLE COVERAGE

SECTION 3 ~ OTHER INSURANCE: Will you, your spouse or your children have any other coverage while on any of the coverages listed above? ☐ Yes ☐ No

If yes, please provide the required information below: Employer Name, Insurance Carrier Name & Address

		TYPE OF COVERAGE		
		MED	DEN	VIS
Self				
Spouse		☐	☐	☐
Child (ren)		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

PARTICIPATION CERTIFICATION: I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWELDGE AND I HAVE READ AND UNDERSTAND THE PARTICIPANT AUTHORIZATION AND STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE REVERSE SIDE OF THIS FORM. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS FOR THE COST OF BENEFITS FOR WHICH I AM OR MAY BECOME ELIGIBLE.

Participant's Signature (*New enrollment or changes only*) Date:

Employer's Signature Date:

Please refer to reverse side of form

MMIA
PO Box 6669
Helena, MT 59604-6669
Fax: 406-449-7440

Participant Authorization

I hereby request coverage for myself and my dependent(s) listed on this enrollment application who are currently enrolled or may become eligible for coverage under the plan agreement purchased by the Montana Municipal Interlocal Authority (MMIA). I agree that my dependents and I will comply with the following:

~ That we will be bound by the terms and conditions of the Group Agreement, as it may be amended;

~ That all providers that have rendered services to me and my dependents are authorized to make medical information and records regarding such services available to the Plan and their providers who, in turn, may share such records among themselves; and,

~ That I shall assist the Plan in the completion and submission of consents, releases, assignments and any other documents related to the protection of the Plan's rights under the Group Agreement including, but not limited to, the coordination of benefits with other health benefit plans, insurance policies or Medicare.

I understand that I am responsible for notifying the Plan within 31 days of any changes in my or my dependent(s)' eligibility status, such as change of address, birth, adoption of a child, marriage, termination or additional coverage.

Statement of HIPAA Portability Rights

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 SHIP. 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.

Health Coverage Waiver Form

Complete this section only if you are waiving coverage for yourself and/or any dependent

If waiving coverage upon initial eligibility and want to continue to waive coverage during the next open enrollment period, you must sign a waiver every plan year during open enrollment. Proof of other creditable group coverage is required with the submission of this waiver.

I decline to enroll in coverage with the MMIA: (please print)

EMPLOYER NAME (CITY/TOWN):	GROUP NUMBER:
EMPLOYEE NAME:	SOCIAL SECURITY NUMBER:

I decline to enroll in the health coverage for:

1. Employee _____
2. Spouse _____
3. Dependent _____
4. Dependent _____
5. Dependent _____
6. Dependent _____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____
(if spouse is waiving coverage)