



**CITY OF MARSHALLTOWN
Healthcare/ Dental Enrollment Form**

NOTE: UPON COMPLETION, THIS FORM REPLACES ANY AND ALL PREVIOUS ENROLLMENT FORMS

GROUP NUMBER 40057

| | |
|---|--------------------------------------|
| EMPLOYEE INFORMATION | |
| EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) | DATE OF BIRTH SOCIAL SECURITY NUMBER |
| STREET/MAILING ADDRESS | |
| CITY, STATE, ZIP | SEX HOME PHONE NUMBER |
| MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED | DATE OF FULL TIME EMPLOYMENT |

MEDICAL/DENTAL COVERAGE REQUEST: -EMPLOYEE/SINGLE -FAMILY
 I DECLINE MEDICAL COVERAGE FOR: -MYSELF AND MY ELIGIBLE DEPENDENTS -MY SPOUSE -MY DEPENDENTS (COMPLETE BACK OF FORM)

DEPENDENT INFORMATION: PLEASE COMPLETE FOR ALL DEPENDENTS COVERED BY THIS REQUEST

| DEPENDENT NAME (FIRST AND LAST) | SEX M/F | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH MO/DAY/YR | SOCIAL SECURITY # | DOES DEPENDENT HAVE OTHER COVERAGE? IF SO, LIST INSURANCE CO. NAME |
|---------------------------------|---------|--------------------------|-------------------------|-------------------|--|
| SPOUSE | | SPOUSE | | | |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

(LIST ADDITIONAL CHILDREN ON AN ATTACHED SHEET.) ATTACH COPIES OF LEGAL COURT CUSTODY DECREES OR QUALIFIED MEDICAL CHILD SUPPORT ORDER

ARE ANY DEPENDENTS AGE 19 AND OVER ELIGIBLE FOR OTHER HEALTH COVERAGE? -YES -NO
 (IF THEY DO BECOME ELIGIBLE FOR OTHER HEALTH COVERAGE, IT IS THE PARTICIPANT'S RESPONSIBILITY TO NOTIFY YOUR HR DEPT. WITH THAT INFORMATION.)

ARE ANY DEPENDENTS AGE 26 AND OVER ATTENDING SCHOOL ON A FULL TIME BASIS? -YES -NO
 (A LETTER FROM THE REGISTRAR CONFIRMING FULL TIME STUDENT STATUS MUST BE PROVIDED BEFORE COVERAGE BEGINS.)

| | |
|-----------------------|-----------------------|
| DEPENDENT NAME/SCHOOL | DEPENDENT NAME/SCHOOL |
|-----------------------|-----------------------|

SPOUSE INFORMATION: COMPLETE ONLY IF REQUESTING COVERAGE FOR SPOUSE IS SPOUSE EMPLOYED? -YES -NO

| | |
|----------------------------------|-------------------------------------|
| SPOUSE'S EMPLOYER (COMPANY NAME) | EMPLOYER ADDRESS (CITY, STATE, ZIP) |
|----------------------------------|-------------------------------------|

DOES YOUR SPOUSE HAVE GROUP MEDICAL INSURANCE THROUGH HIS/HER EMPLOYER? -YES -NO
 IF YES, -SINGLE -FAMILY EFFECTIVE DATE OF COVERAGE:

| | | |
|--|----------------------------|--|
| IS ANY DEPENDENT OR SPOUSE DISABLED? <input type="checkbox"/> -YES <input type="checkbox"/> -NO (QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY) | NAME OF DISABLED DEPENDENT | TYPE OF DISABILITY/DATE DISABILITY BEGAN |
|--|----------------------------|--|

IMPORTANT NOTICE

PLEASE CAREFULLY REVIEW AND SIGN THE REVERSE SIDE.

YOUR SIGNATURE IS REQUIRED BEFORE THIS FORM CAN BE PROCESSED !!



---- **EMPLOYER USE ONLY - PLEASE COMPLETE** ----

| | | |
|--|---|---|
| <input type="checkbox"/> -NEW EMPLOYEE | CHANGE: (CHECK ONE) <input type="checkbox"/> -SPECIAL ENROLLEE <input type="checkbox"/> -LATE APPLICANT <input type="checkbox"/> -COBRA <input type="checkbox"/> -OTHER | DIVISION _____ |
| ➤ PLEASE EXPLAIN CHANGE AND DATE OF "QUALIFYING" EVENT AND EMPLOYEE/DEPENDENT NAMES, IF APPLICABLE: | | |
| MEDICAL/DENTAL COVERAGE : <input type="checkbox"/> -EMPLOYEE/SINGLE <input type="checkbox"/> -FAMILY | <input type="checkbox"/> -DECLINE MEDICAL COVERAGE | |
| HIRE DATE | ELIGIBILITY DATE | ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE |
| | | EFFECTIVE DATE OF CHANGE |
| EMPLOYER AUTHORIZED SIGNATURE | | |
| PRIOR CREDITABLE COVERAGE REQUEST: | | |
| <input type="checkbox"/> -CERTIFICATE ATTACHED | <input type="checkbox"/> -CERTIFICATE TO FOLLOW | <input type="checkbox"/> -NO PRIOR CREDITABLE COVERAGE (NO CERTIFICATE) |

CITY OF MARSHALLTOWN

IMPORTANT INFORMATION: PLEASE READ AND SIGN BELOW

HEALTHCARE PREEXISTING CONDITION; SPECIAL ENROLLMENT PROVISION, DECLINATION AND CONTACT INFORMATION

PREEXISTING CONDITION EXCLUSION RULES

This plan imposes a preexisting condition exclusion for plan participants age 19 and older. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy. This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SPECIAL ENROLLMENT PROVISION

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Medicaid or CHIP: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while on Medicaid or SCHIP you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after you or your dependents lose that coverage.

Dependent Beneficiaries

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage. In addition, if you have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after the birth, adoption, or placement for adoption.

Eligibility for Premium Assistance under Medicaid or CHIP.

If the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP), you may be able to enroll yourself and your eligible dependents. You must request enrollment within 60 days.

DECLINATION OF COVERAGE

If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period (if applicable), unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption. Further, anyone whom you enroll during annual open enrollment will be treated as a "late enrollee" (unless that person happens to be entitled to special enrollment during the annual open enrollment period).

I have been given the opportunity to participate in the group healthcare plan offered by my employer and I decline participation for:

- Myself And My Eligible Dependents: Names: _____
- My Eligible Dependents: Names: _____
- Reason For Declining Coverage (Check One):
- Currently Covered Under Another Medical Benefit Plan
- Other _____

IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.

CONTACT INFORMATION

All questions about the preexisting condition exclusion and creditable coverage should be directed to Membership Representative, First Administrators, Inc., PO Box 9900, Sioux City, IA 51102-0479 or phone 1-800-206-0827.

AGREEMENT, ASSIGNMENT AND AUTHORIZATION

AGREEMENT: I UNDERSTAND THAT IF I HAVE MADE ANY FALSE STATEMENTS OR MISREPRESENTATIONS OR HAVE FAILED TO DISCLOSE OR CONCEALED ANY MATERIAL FACT, FIRST ADMINISTRATORS, INC. WILL BE ENTITLED TO DENY HEALTH CARE BENEFITS.

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PROVIDER OF SERVICE BY MY EMPLOYER'S HEALTHCARE PLAN HEREIN NAMED OF THE GROUP BENEFIT'S PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE, TO OR BY FIRST ADMINISTRATORS, INC. OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. I HEREBY REQUEST THE AMOUNT(S) AND FORMS FOR COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE, AND HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS.

I HAVE READ AND COMPLETED ALL OF THE INFORMATION OUTLINED ABOVE

EMPLOYEE SIGNATURE

DATE SIGNED