



Request for Enrollment Change

Section 1: POLICY INFORMATION		
Employer Name	Policy Number / Group ID	Effective Date of Change
Employer Approved (Signature Required)		

Section 2: TYPE OF CHANGE
<p>Indicate Type of Change Below</p> <p><input type="checkbox"/> Name Change – If your name has changed, please indicate YOUR PRIOR name so we can correctly identify you: _____</p> <p><input type="checkbox"/> Add Dependant <input type="checkbox"/> Drop Dependant (complete a Waiver Form) <input type="checkbox"/> Drop Coverage (complete a Waiver Form)</p>

Section 3: EMPLOYEE INFORMATION				
Employee Name (First Middle Last)	Social Security Number	Telephone Number		
Address	City	State	Zip	

Section 4: CHANGE DETAILS

Change my enrollment as indicated below:										
Name, (First, Middle, Last) Name	Sex	Social Security Number	Date of Birth	Relationship	Resides with employee?	MED	DEN	VIS		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Add <input type="checkbox"/> Drop		

Any dependents listed above must meet the definition of a dependent as listed in the Plan Document. If a dependent child is over the age of 21 (and if your plan requires this) is he/she a full time student? Yes No

If yes, please indicate name of school or volunteer organization: _____

Reason for Add/Change	Reason for Drop
<input type="checkbox"/> Newborn Date of Event <input type="checkbox"/> Adoption / Court Order (attach proof) Date of Event <input type="checkbox"/> Marriage Date of Event <input type="checkbox"/> Other: _____ Date of Event <input type="checkbox"/> Age 21+ Dependant Returning to School Date of Event <input type="checkbox"/> Loss of Other Coverage Date of Event Reason for Loss: _____ <i>(Include a Certificate of Creditable Coverage)</i>	<input type="checkbox"/> No Longer A Full Time Student Date of Event <input type="checkbox"/> Divorce or Legal Separation Date of Event (circle one) <input type="checkbox"/> In Anticipation of Divorce Date of Event <input type="checkbox"/> Ineligible Dependant Date of Event Reason Ineligible: _____ <input type="checkbox"/> Waiving Coverage: (You must complete the Waiver Form for every covered person, including the reason) Date of Event

Section 5: OTHER INSURANCE

<p>Do you or your enrolled family members have any OTHER coverage that you will keep? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>* IF YES, please give name of each person covered, the other Plan Name, Address and Phone Number:</p> <p>_____</p> <p>* Please include a copy of your Certificate of Creditable Coverage from your prior employer/carrier.</p>

Section 6: SIGNATURE

I UNDERSTAND that providing inaccurate or incorrect information to any of the answers above may be considered health care fraud.

Employee Signature_____
Date**Statement of HIPAA Portability Rights**

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee.) Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 31 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Creditable coverage includes: a group health plan, COBRA continuation coverage, health insurance coverage, Medicare, Medicaid, coverage under Title 10, Chapter 55, United States Code (Tricare), Montana Comprehensive Health Association, a health plan offered under Title 5, chapter 89 of the United States Code (Federal Government Plan), State Children's Health Insurance Program (SCHIP), coverage through a high-risk pool in any state, the Peace Corps, a medical program of Indian health service or tribal organization, foreign nationalized healthcare coverage, and a public health plan. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days from the date the Certificate of Credible Coverage was issued or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

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.

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.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.
- The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.
- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Please Mail Completed Form To:

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