MMIA MONTANA MUNICIPAL INTERLOCAL AUTHORITY

EMPLOYEE BENEFITS

Benefit Enrollment, Termination or Change Form for FY 2021-2022

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:**

REQUIRED

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: _____

***First Day of Work is the date an employee meets the minimum eligibility requirements. The Waiting period begins on that date.**

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

☐ Waive Medical Coverage - **You must complete the medical waiver below.**

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	Currently/ previously employed as a firefighter?	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

Health Coverage Waiver Form

Complete this section only if you are waiving medical coverage for yourseld and any dependent.

If waiving coverage upon initial eligibility and want to contine to waive coverage during the next open enrollment period, you must sign a waiver every plan year during open enrollment.

I decline to enroll in the health coverage available with the MMIA:

Employee: _____

Spouse: _____

Child(ren): _____

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

See page 2 for authorization and signature area.

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Please print clearly on entire form.

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		
Self		MED	DEN	VIS
Spouse		☐	☐	☐
Child (ren)		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

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, separation/divorce, termination or additional coverage.

Statement of HIPAA Portability Rights

IMPORTANT – KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to help you get special enrollment in another plan, or to get certain types of individual health coverage.

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 within 30 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.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health Elaws.

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. 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 (Not required for termination) Date:

Employer's Signature Date: