



Montana Municipal Interlocal Authority
EMPLOYEE BENEFITS PROGRAM ENROLLMENT FORM

Please fax to: 406-449-7440 or submit to:
 PO Box 6669 ~ Helena, MT 59604-6669

Group Name: (City/Town)		Group Number:			<i>Please print clearly on entire form</i>	
Last Name	First Name	Initial	Work Phone	Home Phone	Cell Phone	
Current Address		City	State	Zip	<i>If waiving coverage stop here and proceed to the back side of this form</i>	
<i>Please use this form for New Enrollments, Changes and Terminations - disregard all previous Enrollment, Change & Termination forms</i>						

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

Part A - New Enrollment	Part B - Enrollment Changes	Event Date
Effective Date of Coverage: _____	Add/Drop spouse or dependent (Open enrollment & Qualifying Event Only)	
First Day of Work: _____	Medicare eligible (provide copy of card or letter)	
Hours worked per week: _____	Retiree Status	
Plan Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Spouse	Death	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Other (reason):	
Medical Plan Choice - Please check only one appropriate box below:	Ineligible Dependent (reason):	
<input type="checkbox"/> Bridger <input type="checkbox"/> Madison <input type="checkbox"/> Mission <input type="checkbox"/> HDHP <input type="checkbox"/> Custom	Address Change (former address):	
	Name Change (former name):	
Part C - Termination of Coverage <i>If staying on coverage as a retiree see Part B</i>	Medical Plan Choice - Open Enrollment & Qualifying Events Only	
Last day worked _____ Last day eligible for benefits _____	<input type="checkbox"/> Bridger <input type="checkbox"/> Madison <input type="checkbox"/> Mission <input type="checkbox"/> HDHP <input type="checkbox"/> Custom (if applicable)	
<input type="checkbox"/> Voluntary by employee <input type="checkbox"/> Involuntary by employer	<i>Must provide supporting legal documentation of divorce, marriage, adoption, etc. with this form</i>	
Type of Qualifying Event (Term, Resignation, Reduce Hrs, Death): _____		
Coverage will end the last day of the month in which employee was terminated.	<i>Notes: Use this space for clarification on any of the above</i>	

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	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	
New enrollee - must complete employee info also																	
Employee:							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse:							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren): (list)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: IF YOU OR YOUR DEPENDENTS HAD COVERAGE WITHIN THE LAST 63 DAYS, 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

	<input type="checkbox"/> Yes <input type="checkbox"/> No	TYPE OF COVERAGE		
		MED	DEN	VIS
Self	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child (ren)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4 ~ BENEFICIARY (for groups with group life insurance coverage)

PRIMARY - FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT
CONTINGENT- FULL NAME				

PARTICIPATION CERTIFICATION: I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE 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: _____

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

Employee Name: _____

Group Employer Name (city/town): _____

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

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 conditions 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 30 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. Most health coverage is creditable coverage, including group health plan coverage. COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (CHIP), and coverage through high-risk pools and the Peace Corps. 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 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 the 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);
- 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.

Health Coverage Waiver

(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 for: (please print)

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

Employees may waive coverage if they have other group health coverage, and provide evidence of such acceptable coverage. Please submit evidence of coverage under another group health plan with this form.

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 "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 for any pre-existing condition, as that term is defined by Federal Law (HIPAA).

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

(if spouse is waiving coverage)