HEALTH BENEFIT PLAN ENROLLMENT FORM

COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE REVIEW THE STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE BACK.

Company / Employer Name:
COLLIER COUNTY GOVERNMENT

Type of Benefits:
❒ Medical ❒ Vision ❒ Disability
❒ Dental ❒ Life ❒ Other

EMPLOYEE NAME (FIRST) (INITIAL) (LAST)

ADDRESS

SOCIAL SECURITY NO. (required by law) - -
SEX (M OR F)
BIRTH DATE - -

CITY STATE ZIP

DATE OF HIRE - -
☐ Single ☐ Widowed ☐ Divorced ☐ Married

HOME PHONE NUMBER ( ) -
WORK PHONE NUMBER ( ) -

OCCUPATION/JOB TITLE
EARNINGS (IF APPLICABLE) $ **PER**

E-MAIL ADDRESS

FOR COMPANY USE ONLY
PLAN# 2003021 **DEPT.** **EFFECTIVE DATE**

BENEFICIARY (FIRST) (INITIAL) (LAST)
BIRTHDATE - -
RELATIONSHIP

(STREET) (CITY) (STATE) (ZIP)
(AREA CODE) PHONE NUMBER

DEPENDENTS (Use additional paper, if necessary)

FIRST INITIAL LAST	SOCIAL SECURITY NUMBER (required by law)	BIRTH DATE	SEX	RELATIONSHIP	RESIDES WITH EMPLOYEE YES / NO		TO BE COVERED YES / NO	
LEGAL SPOUSE Marriage Date - -					☐	☐	☐	☐
List Child					☐	☐	☐	☐
List Child					☐	☐	☐	☐
List Child					☐	☐	☐	☐
List Child					☐	☐	☐	☐

Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description.

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered health care fraud.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

SIGNATURE OF APPLICANT **DATE**

COMPLETE WAIVER FORM ON BACK IF YOU AND/OR YOUR DEPENDENTS CHOOSE NOT TO BE COVERED BY THIS HEALTH BENEFIT PLAN

HEALTH COVERAGE WAIVER FORM

(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)

COMPANY / EMPLOYER NAME: **COLLIER COUNTY GOVERNMENT**	**GROUP NUMBER** 2003021
EMPLOYEE NAME: (LAST) (FIRST) (INITIAL)	**SOCIAL SECURITY NUMBER**

I <u>decline</u> to enroll in the health coverage for:

☐ Myself ☐ My Spouse Reason for waiver: ☐ The existence of other coverage _____ (Plan Name)

☐ My Dependent Child/Children (please list) ☐ Other reason (explain)_____

1._____ 4._____

2._____ 5._____

3._____ 6._____

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 "Special 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'S SIGNATURE _____ DATE SIGNED _____

SPOUSE'S SIGNATURE _____ DATE SIGNED _____
(If Spouse is waiving coverage)

Statement of HIPAA Portability Rights

<u>Pre-existing condition exclusions.</u> 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 covered person who is less than nineteen (19) years of age.

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 (SCHIP), 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.

<u>Right to get special enrollment in another plan.</u> 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.

<u>Prohibition against discrimination based on a health factor.</u> 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.

<u>Right to individual health coverage.</u> 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.

I ACKNOWLEDGE that I have read the statement of HIPAA Portability Rights.

I have prior creditable coverage □ Yes □ No. If yes, I understand I must submit a certificate of creditable coverage to Allegiance Benefit Plan Management, Inc.

OTHER HEALTH INSURANCE INFORMATION

Other Health Coverage?* ❑ **Yes (complete below)** ❑ **No**

***Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage.**

Please check the coverage currently being provided elsewhere: ☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision

List all family members, including yourself, who will continue to be covered by other health coverage in addition to this plan:

Self: □ Yes □ No	**Spouse:** □ Yes □ No (If yes, continue below)	**Child(ren):** □ Yes □ No (If yes, continue below)

SPOUSE:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:

Name, Phone Number and Address of other insurance company:	Policy/Certificate Number:	Effective Date:
Policyholder's name:	Social Security Number:	Date of Birth:

If you and/or your dependents are enrolled in Medicare Part A, Part B, and/or Part D, or Medicaid, please complete the following fields:

Enrollee's name(s):	Medicare/Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:

<u>IF PARENTS OF DEPENDENT CHILD(REN) WERE NEVER MARRIED OR IF THEY ARE NOW SEPARATED OR DIVORCED</u>: Please answer the following questions for dependent children in order to determine which coverage has primary liability

Date of divorce or separation (if applicable):	Is there a court order making one parent responsible for the child's medical, dental, or vision expenses? □ Yes □ No ***If yes, please provide a copy of the divorce decree or parenting plan.**

Which parent has physical custody of the child? Name _____ DOB _____

Has the parent with custody remarried? □ Yes □ No

If yes, does the step-parent cover this child? □ Yes □ No *If yes, please provide insurance information below

Name, Phone Number and Address of other insurance company:	<u>Policyholder's Name:</u> <u>Policyholder's Date of Birth:</u>	Policy/Certificate Number:

<u>Effective Date of Coverage:</u> <u>Termination Date of Coverage (if applicable):</u>	Type of Coverage: ❒ Medical ❒ Prescription ❒ Dental ❒ Vision	Members on the Plan: _____ _____ _____ _____