EMPLOYEE HEALTHCARE/LIFE ENROLLMENT FORM

Health Pool of South Dakota

Group Name_____**Group Number**_____

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

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: ☐-SINGLE ☐-MARRIED ☐-DIVORCED ☐-WIDOWED	DATE OF FULL TIME EMPLOYMENT	

COVERAGE REQUEST:
- EMPLOYEE/SINGLE ☐-HEALTH ☐-LIFE (IF APPLICABLE) AMOUNT OF COVERAGE $_____
- SPOUSE ☐-HEALTH ☐-LIFE (IF APPLICABLE)
- CHILDREN ☐-HEALTH ☐-LIFE (IF APPLICABLE)

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.					

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

ARE ANY DEPENDENTS OVER THE AGE OF 25 ELIGIBLE FOR OTHER HEALTH COVERAGE? ☐-YES ☐-NO
(IF THEY DO BECOME ELIGIBLE FOR OTHER HEALTH COVERAGE, IT IS THE PARTICIPANTS RESPONSIBLITY TO NOTIFY THE HR DEPT WITH THAT INFO).

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:

IF YOU OR ANY DEPENDENT(S) LISTED ABOVE WILL BE COVERED BY MEDICARE WHILE ENROLLED IN THIS HEALTH PLAN, PLEASE COMPLETE THE FOLLOWING:

ENROLLEE NAME	MEDICARE #	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	IS MEDICARE ELIGIBILITY DUE TO: ☐-KIDNEY FAILURE ☐-DISABILITY

IS ANY DEPENDENT OR SPOUSE DISABLED? ☐-YES ☐-NO (QUESTION ASKED FOR COORDINATION OF BENEFITS INFO ONLY)	NAME OF DISABLED DEPENDENT	TYPE OF DISABILITY/DATE DISABILITY BEGAN

LIFE INSURANCE BENEFICIARY DESIGNATION LIST YOUR PRIMARY AND CONTINGENT (2ND CHOICE) BENEFICIARIES HERE. IF YOU LIST MORE THAN ONE PRIMARY OR CONTINGENT BENEFICIARY, YOUR BENEFIT WILL BE DIVIDED EQUALLY AMONG THE SURVIVING BENEFICIARIES UNLESS YOU INDICATE OTHERWISE. YOU MAY CHANGE YOUR BENEFICIARY AT ANY TIME. (IF BENEFICIARY IS A TRUST, GIVE COMPLETE NAME OF TRUST AND TRUSTEE.)

PRIMARY BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU	CONTINGENT BENEFICIARY NAME(S) AND RELATIONSHIP TO YOU

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* - - - -

☐-NEW EMPLOYEE

CHANGE: (CHECK ONE) ☐-SPECIAL ENROLLEE ☐-LATE APPLICANT ☐-COBRA ☐-RETIREE ☐-OTHER

➢ ***PLEASE EXPLAIN CHANGE AND DATE OF "QUALIFYING" EVENT AND EMPLOYEE/DEPENDENT NAMES, IF APPLICABLE:***

COVERAGE REQUEST:
- EMPLOYEE/SINGLE ☐-HEALTH ☐-LIFE AMOUNT $_____ ☐-DECLINE MEDICAL COVERAGE
- SPOUSE ☐-HEALTH ☐-LIFE ☐-DECLINE MEDICAL COVERAGE
- CHILDREN ☐-HEALTH ☐-LIFE ☐-DECLINE MEDICAL COVERAGE

HIRE DATE	ELIGIBILITY DATE	ORIGINAL EFFECTIVE DATE OF MEDICAL COVERAGE	EFFECTIVE DATE OF CHANGE	***EMPLOYER AUTHORIZED SIGNATURE***

PRIOR CREDITABLE COVERAGE REQUEST:

☐-*CERTIFICATE ATTACHED*	☐-*CERTIFICATE TO FOLLOW*	☐-*NO PRIOR CREDITABLE COVERAGE (NO CERTIFICATE)*

THE HEALTH POOL OF SOUTH DAKOTA

IMPORTANT INFORMATION: PLEASE READ AND SIGN BELOW

HEALTHCARE SPECIAL ENROLLMENT PROVISION, DECLINATION AND CONTACT INFORMATION

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 SCHIP: 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.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, 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 should be directed to The Health Pool of South Dakota at 1-800-658-3633 or Wellmark Customer Service at 1-800-774-0384.

ASSIGNMENT AND AUTHORIZATION

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 WELLMARK BLUE CROSS BLUE SHIELD OF SOUTH DAKOTA 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**