Employee Healthcare Enrollment Form

Health Pool of South Dakota

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial)	Date of Birth (M/D/Y) / /	Social Security No. - -
Street/Mailing Address	Email Address	
City, State, Zip	Sex (M/F)	Primary Phone No.
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		

COVERAGE REQUEST

Employee/Single: ☐ Health ☐ Life	Spouse: ☐ Health ☐ Life	Children: ☐ Health ☐ Life

I **decline** medical coverage for: ☐ Myself and my eligible partner ☐ My spouse ☐ My dependents

SPOUSE/DEPENDENT INFORMATION

Please complete for all dependent covered by this request.
List additional children on an attached sheet. Attach copies of legal court custody decrees or qualified medical child support order.

Spouse	Name (Last, First, Middle Initial)			Relationship to Employee: Spouse	Date of Marriage / /
	Sex (M/F)	Date of Birth / /	Social Security No. - -	Does the dependent have other coverage? If so, list insurance co. name.	
1.	Name (Last, First, Middle Initial)			Relationship to Employee	Full Time Student? ☐Y ☐N
	Sex (M/F)	Date of Birth / /	Social Security No. - -	Does the dependent have other coverage? If so, list Insurance co. name.	
2.	Name (Last, First, Middle Initial)			Relationship to Employee	Full Time Student? ☐Y ☐N
	Sex (M/F)	Date of Birth / /	Social Security No. - -	Does the dependent have other coverage? If so, list insurance co. name.	
3.	Name (Last, First, Middle Initial)			Relationship to Employee	Full Time Student? ☐Y ☐N
	Sex (M/F)	Date of Birth / /	Social Security No. - -	Does the dependent have other coverage? If so, list insurance co. name.	

Are any dependents over the age of 25 eligible for other health coverage? (If they do become eligible for other health coverage, it is the participant's responsibility to notify the HR department with information.) ☐ Yes ☐ No

Complete only if requesting coverage for spouse.

Is spouse employed? ☐Y ☐N	Spouse's Employer (Company Name)	Employer Address (City, State, Zip)

Does your spouse have group medical insurance through their employer? ☐ Yes ☐ No	If yes, ☐ Single ☐ Family		Effective Date of Coverage / /

Complete if you or any dependent(s) listed above will be covered by Medicare while enrolled in this health plan.

Enrollee Name	Medicare No.	Part A Effective Date / /	Part B Effective Date / /	Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability

Is any dependent or spouse disabled? (Question asked for coordination of benefits only.) ☐ Yes ☐ No	Name of Disabled Dependent	Type of Disability: Date Disability Began : / /

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.
QUESTIONS: Direct to The Health Pool of South Dakota at 1-800-658-3633 or Wellmark Customer Service at 1-800-774-0384.

SIGNATURE I have read and completed all of the information outlined above.

Print Full Name	Signature	Date
		/ /

EMPLOYER MUST COMPLETE

☐ New Employee Change (check one): ☐ Special Enrollee ☐ Late Applicant ☐ COBRA Retiree ☐ Other			
Group Name		Group Number	
Explain change and date of "qualifying" event and employee/dependent names, if applicable.			
Hire Date / /	Eligibility Date / /	Original Effective Date of Medical Coverage / /	Effective Date of Change / /
Hours Per Week	Job Title		
Employer Authorized Signature			