MUNICIPAL HEALTH
P.O. BOX 188
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MUNICIPAL HEALTH

HEALTH BENEFIT APPLICATION EMPLOYEE CHANGE FORM

DATE TO BE EFFECTIVE: _____ Municipal Health Use Only

GROUP NAME: _____ GROUP NUMBER: _____

1. REASON FOR COMPLETING THIS FORM

I am a:

- ☐ New Employee
- ☐ Current Employee
- ☐ Late Enrollee

This form is completed in order to officially:

- ☐ Add Dependents to Coverage
- ☐ Drop Dependents from Coverage
- ☐ Enroll in Retiree Coverage (Optional Benefits do not apply)

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer _____ Social Security Number _____

3. BENEFIT SECTION

OPTIONAL BENEFITS (ONLY APPLICABLE IF ELECTED BY YOUR EMPLOYER & YOU ARE ENROLLED IN MEDICAL COVERAGE)

- ☐ Option A Disability
- ☐ Option B Disability
- ☐ Life Insurance: Volume Amount $ _____
- ☐ AD&D: Volume Amount $ _____

Enrollment Status for which you are Applying/Enrolling (please choose one)

- ☐ Employee ONLY
- ☐ Family

Please complete the table below for each family member: (for each benefit enter A to ADD or D to DROP)

	Last Name	First Name	Social Security #	Birth Date	Sex F/M	Medical	Dental	Vision
01 Self								
02 Spouse								
03 Child								
04 Child								
05 Child								
06 Child								
07 Child								

(If other type of dependent (stepchild, grandchild, etc.), please provide supporting documentation)

4. OTHER INSURANCE

Will you or any member of your family be covered under OTHER health or medical insurance while Municipal Health is active?

◯ Yes ◯ No

If yes, who will be covered? ☐ 01 Self ☐ 02 Spouse ☐ 03 Child ☐ 04 Child
☐ 05 Child ☐ 06 Child ☐ 07 Child

1. OTHER Insurance Company Name or Plan: _____
Address: _____ Phone #: _____
Policy # (should be listed on card): _____ Effective Date: _____
Please include copy of front and back of insurance card

2. OTHER Insurance Company Name or Plan: _____
Address: _____ Phone #: _____
Policy # (should be listed on card): _____ Effective Date: _____
Please include copy of front and back of insurance card

3. OTHER Insurance Company Name or Plan: _____
Address: _____ Phone #: _____
Policy # (should be listed on card): _____ Effective Date: _____
Please include copy of front and back of insurance card

5. MEDICAL WAIVER SECTION

Complete this Section **ONLY** if you are Waiving (declining) the health coverage available to you through your employer. If you are **choosing NOT to enroll, COMPLETE THIS SECTION**. If your employer pays 100% of the employee cost of this health care coverage, you must enroll in this Health Plan for the employer to be considered eligible.

WAIVER: This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through the employer named in Section 2. I hereby waive the health coverage offered. I am waiving the health coverage and declining to enroll because : (form will be incomplete if selection is not marked)

☐ Spousal Coverage
☐ Coverage Under Another Plan
☐ Individual Health Coverage
☐ Medicare, Medicaid, or Medical Supplement Coverage
☐ Other: _____

(if waiving, you MUST check/complete one of the above)

I attest that I was not pressured nor forced by the employer named in Section 2, the writing agent, MHBP, or any other outside party who might have a vested interest in my waiving (declining) the above noted coverage. I further realize that any future application for coverage under this plan may require additional limitations, waiting periods, or other applicable terms and conditions of a master group contract that would impact my benefits. I also understand that I may be asked to supply additional statements of health for any future enrollment. I freely and voluntarily waive (decline) the above noted coverage.

Employee Signature: _____ **Date:** _____

Please make sure Section #1 and #2 are completed and read even if you waive or decline coverage.

6. NOTICE AND ACCEPTANCE OF PLAN PROVISIONS

You must sign this form on your behalf and your dependents. You must return this signed form to your employer. If you do not sign and return this form to your employer the Program will not provide you or your dependents with coverage.

When you sign the form you are agreeing that you have received a copy of the Privacy Notice and the Summary of Benefits and Coverage (SBC). These are two separate documents.

By signing the form you also acknowledge that you may obtain a copy of the Municipal Health Benefit Program Bylaws at www.arml.org and that you agree to accept the terms and conditions of the Municipal Health Benefit Program.

The Progam's Plan is subject to Federal law, including, the Patient Protection and Affordable Care Act and the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). COBRA provides for the extension of coverage under the Plan should certain special

life events take place. (See the Declaration of Trust on page 1 of the Program Bylaws for more information).

Federal law also allows the Program to exempt the Program from some requirements imposed by Federal law. The Program has done so. (See page 1.)

You further acknowledge that although the Plan may have provided benefits for an illness or condition in past years, the Plan does not necessarily provide benefits for those illnesses or conditions in subsequent Plan years.

By signing below you authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Program that may be necessary to determine benefits payable.

Your authorization for the release of records to determine benefits payable also provides for the release of records of your eligible covered dependents. Your authorization shall remain in effect until changed or updated by you or the Plan. An electronic or photostatic copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only.

You may revoke your medical authorization on your behalf or that of your eligible covered dependent by providing a written revocation to the Program.

If you or your eligible dependent(s) changes their coverage status by dropping coverage or changing coverage to a different group then a new certificate must be signed. All new employees are required to execute this Certificate of Notice and Acceptance of Plan Provisions.

Signature of Proposed Insured Employee	**Date**
Signature of Group Representative	**Date**

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