Allegiance℠
Life & Health Insurance Company

Request for Enrollment Change

Employee Information (required)

☐ **Name Change –** If your name has changed, please indicate **YOUR PRIOR** name so we can correctly identify you: Prior Name:_____		☐ **Add Dependent** ☐ **Drop Dependent (complete waiver section)** ☐ **Drop Coverage (complete waiver section)**		
Employer Name	**Policy/Group Number**	**Effective Date of Change**		**Division**
Employee Last Name	**Employee First Name**	**Social Security Number**		**Phone Number**
Address	**City**	**State**	**Zip**	**E-mail Address**

Change My Enrollment As Indicated Below

Last Name, First Name	**Gender**	**Social Security Number**	**Date of Birth**	**Relationship To Employee**	**MED**		**DEN**		**VIS**	
					Add	**Drop**	**Add**	**Drop**	**Add**	**Drop**

Reason For Add/ Change (indicate below)			**Date of Event**	**Reason for Drop (indicate below)**			**Date of Event**
Newborn DOB				**Divorce or Legal Separation (circle one)**			
Adoption / Court Order (attach proof)				**In Anticipation of Divorce**			
Marriage (date of Marriage required)				**Other:**			
Loss of Other Coverage **Reason for loss:_____** **(You must provide a Certificate of Creditable Coverage)**				**Ineligible Dependent** **Reason: _____** **(If waiving coverage, complete waiver section)**			

Eligible Dependent means a legal spouse, a domestic partner, provided all eligibility criteria are met, a dependent child under the age of 26 who is a natural child, stepchild, legally adopted child, or a child placed with the applicant for adoption.

Other Insurance Information Required

Do you or your enrolled family members have any OTHER coverage? (That you will keep in addition to this coverage.) ☐ **YES*** ☐ **NO**
*** IF yes**, please complete the fields below:
Type of Coverage: Medical ___ Pharmacy ___ Dental ___Vision ____ Effective Date:_____ Date Coverage will end: _____
Family covered under the other health plan: Self ___ Spouse ___ Name(s) of Child(ren): _____ _____ _____
Name, Phone Number, and Address of other insurance company: _____
Policy Holder's Name: _____ Policy Number: _____ ID #:_____

I understand that providing false, incomplete, inaccurate, or incorrect information to any of the questions above may be considered insurance fraud and may result in denial or cancellation of coverage.

_____ _____
Employee Signature (required) **Date** (required)

_____ _____
Employer Signature (required) **Date** (required)

Health Coverage Waiver Form

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

Employer Name	**Policy Number**
Employee Name (LAST) (FIRST) (INITIAL)	**Social Security Number**

I decline to enroll in health coverage for

☐ Myself ☐ My Spouse ☐ My Dependent Child/Children (please list) _____

Reason for waiver:

☐ the existence of other coverage (Plan Name) _____

☐ other reason (explain)_____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date.

_____ _____

Employee's Signature Date Spouse's Signature (if waiving) Date

Statement of HIPAA Portability Rights

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.

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 CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

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 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.