INSURANCE ENROLLMENT/DECLINATION FORM
(Health, Dental & Vision)

SECTION 1 - ENROLLMENT REASON

☐ New Hire ☐ Qualifying event - Reason:_____

Effective Date of Change: _____

☐ Open Enrollment ☐ Address Change ☐ Name Change ☐ Other _____

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security Number
Street/Mailing Address	Phone Number	
City, State, Zip	Marital Status	Date of Hire

SECTION 3 – MEDICAL ELECTION (GROUP No. PKA20398)

☐ $500 Plan

☐ $750 Plan

Medical Coverage Request:

☐ Employee/Single ☐ Family

DECLINATION OF MEDICAL COVERAGE

I have been given the opportunity to participate in the group healthcare plan offered by my employer and I **decline** participation for:

☐ Myself ☐ My Eligible Dependents: Names: _____

REASON FOR DECLINING COVERAGE (CHECK ONE):

☐ Currently Covered Under Another Medical Benefit Plan ☐ Other _____

IMPORTANT NOTE:
This form must be completed and on file with your employer for the special enrollment period described on page 2 to apply.

SECTION 4 – DENTAL ELECTION (GROUP No. 32388)

☐ BASIC Dental Plan

☐ BUY UP Dental Plan

Dental Coverage Request:

☐ Employee/Single ☐ Family

☐ I decline participation in the dental plan.

IMPORTANT NOTE: *Your Dental Monthly Premium is based on your Medical Election/Declination.* ***If you decline Medical, but elect a dental plan, you WILL HAVE a Monthly Dental Premium (please see Dental Flyer for Monthly Dental Premium Amounts).***

SECTION 5 – VISION ELECTION (GROUP No. 60790-1574 PLAN No. 962)

☐ Single ☐ Family ☐ I decline participation in the vision plan.

SECTION 6 - DEPENDENT INFORMATION

List those dependents (spouse and dependent children) for whom you are electing/removing coverage ***("A"*** *for Add;* ***"R"*** *for Remove).* List additional dependents on an attached sheet. Attach copies of custody decrees or Qualified Medical Child Support Order.
("H" = Health, "D"= Dental, "V"=Vision)

Dependent Name (Last, First, MI)	H	D	V	Relationship *(Spouse/Child)*	Gender	Date of Birth	Social Security	Other Insurance Coverage (Carrier Name)

Please carefully review the entire enrollment form. Your signature on page 2 is required before this form can be processed.

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SECTION 7 - SPOUSE INFORMATION (Complete only if requesting coverage for spouse)

Is spouse employed? ☐ Yes ☐ No ; If YES, does spouse have group medical coverage through their employer? ☐ Yes ☐ No	
If YES to coverage through their employer, ☐ Single ☐ Family	Effective Date of Coverage:
Spouse's Employer Name:	Employer Address (City, State, Zip)

SPECIAL ENROLLMENT PROVISION

Life Events: Did you recently get married or divorced, have a child, or lose coverage you had through Medicaid, CHIP, or another group health plan?

These are some examples of qualifying events that may provide you with a SPECIAL ENROLLMENT PERIOD so that you may add or remove yourself and/or your dependents from our health plan outside the annual open enrollment period. Generally, you have 31 days from the date of your qualifying event to make a change. So if you have one of these life events, be sure to contact Human Resources at 319-833-3009 as soon as possible!

AGREEMENT, ASSIGNMENT, and AUTHORIZATION

I hereby authorize payments directly to the provider of services by my employer's medical and prescription drug plans herein named the group benefits payable to me. I understand I am financially responsible for changes not covered by this assignment. I understand that my insurance premiums will be automatically deducted from my paycheck on a pre-tax basis. I understand that if I desire my premiums to be paid on an after-tax basis, I must provide a written request. Written requests should be submitted to the Human Resources Office or Auditor's Office with a completed enrollment form. I further agree that any errors made relative to insurance premium deductions will be adjusted accordingly either in my favor (refunding premiums) or in the County's favor (deducting missed/inaccurate premiums). Repayment arrangements will be made between the affected employee and the Payroll Department on a case-by-case basis.

I hereby verify that all of the information specified on this form is accurate and complete. By signing below, I have authorized the release of information for myself and my covered dependents to the appropriate administrators.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law.

For the protection of all of our members, fraud or misrepresentation of material fact for the purposes of defrauding the insurance company may result in the insurance company taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

PLEASE NOTE: **Failure to fully complete this form may result in this form being returned to you and will delay the processing of the form. It is recommended that you keep a copy of this form for your own personal record.**

I have read and completed ALL of the information outlined above.

_____ _____

Employee Signature **Date**

FOR INTERNAL OFFICE USE ONLY

Employer Required Information

Unit#: _____ Location/Division: _____ Eligibility/Effective Change Date: _____

Medical Plan _____ Dental Plan _____ Vision Plan_____

Authorized Black Hawk County Signature: _____

☐ PreferredOne (medical) ☐ Delta Dental (dental) ☐ Avesis (vision) ☐ Auditor ☐ Employee