(Form on following page)

INSTRUCTIONS FOR COMPLETING THIS HEALTH PLAN FORM:

FORM SHOULD BE SUBMITTED WITHIN 30 DAYS OF A QUALIFYING EVENT

- **ENROLL** – Select New Contract as the Nature of Application.
- **CANCEL** – Select Waive/Cancel Contract as the Nature of Application.
- **ADDING DEPENDENTS** – Select Add Dependent as the Nature of Application.
    - All current dependents already on your plan should be included on the form in addition to the new dependent.
    - Provide dependent verification document only for the dependent you are adding.
- **REMOVING DEPENDENTS** – Select Remove Dependent as the Nature of Application.
    - Do not include the dependent(s) you are removing on the form.
- **CHANGING PLANS** – Select Plan Change as the Nature of Application.
    - Select which medical plan you wish to transfer to.

View Qualifying Event Chart for required documentation

Documentation is not required for dependents already on your plan

THE EFFECTIVE DATE WILL BE THE QUALIFYING EVENT DATE IF SUBMITTED WITHIN 30 DAYS

RETURN FORM TO BENEFITS OFFICE:

Handmail: City Hall Benefits Office 106

Fax: 334.625.2316

E-Mail: benefits@montgomeryal.gov

Group Health Plan Enrollment/Change Form

Enrollment/Change forms must be typed or printed neatly and to its entirety.
Partially completed forms will not be accepted or processed.

Benefits Office Use Only:

Code: DEDDate:

EMPLOYEE INFORMATION

SSN	Last Name	First Name	M.I.	Gender	Date of Birth (mm/dd/yyyy)
				☐ Male ☐ Female	

Mailing Address (Street)	City	State	Zip	Phone Number

Marital Status	E-Mail	Employee ID #	Department
☐ Single ☐ Married			

GROUP HEALTH PLAN *(Medical, Dental, Prescription, Mental Health, Substance Abuse, & City Wellness Centers)*

Medical Plan Election	Single	Family
☐ HMP (Health Management Plan) - Group 75672	☐	☐
☐ Traditional PPO Plan - Group 73433		

COORDINATION OF BENEFITS – If you are covered by another health plan, please give the following information. Attach proof to this document.

Name of Contract Holder	Name of Insurance Company	Contract Number	Group Number	Effective Date

NATURE OF APPLICATION

☐ New Contract	☐ Waive/Cancel Contract	Change Contract ☐ Plan Change ☐ Coverage Change	Add Dependent ☐ Add Spouse ☐ Add Child	Remove Dependent ☐ Remove Spouse ☐ Remove Child

Event Type	Date Event Occurred / Effective Date
☐ Newly Eligible/New Hire (Hire Date: _____) ☐ Open Enrollment ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Loss/Gain of Coverage ☐ Death	_____

LIST ALL DEPENDENTS COVERED UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.

NOTE: Copies of dependent verification (marriage certificate, birth certificate, adoption/custody paperwork) must be submitted with this application for all dependents.

Last Name	First Name	M.I.	Relationship	Social Security No.	Date of Birth (mm/dd/yyyy)
			☐ HUSBAND ☐ WIFE		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		
			☐ SON ☐ DAUGHTER		

☐ I am electing to waive/cancel the City of Montgomery Group Health Plan benefits. I understand future enrollment into the plan must be done during the annual Open Enrollment period unless I experience a qualifying event. Changes due to a qualifying event must be made within 30 days of the event.

☐ I apply for the Group Health Plan benefits for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (City of Montgomery) and applicable plan carriers. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay plan carriers directly and I give my Group the right to deduct my part of the premiums from my pay (if applicable).

Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees.

I will cooperate with you if you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I am allowed 30 days from my hire date to make changes to this application or to waive coverage completely. After my 30 day grace period has passed, I will not be able to make any other changes to my health plan until the annual Open Enrollment period unless I experience a qualifying event. Changes due to a qualifying event must be made within 30 days of the event.

I acknowledge by my signature that I have read and understand the important information above.

Signature of Employee	Date Signed	Signature of Authorized Representative	Date Signed

Submit signed Enrollment/Change Form to the City of Montgomery Benefits Office.

Benefits Division: 103 N. Perry St., Montgomery, AL 36104 **Ph#:** 334-625-3692 **Fax#:** 334-625-2316 **E-mail:** benefits@montgomeryal.gov