Kirkwood COMMUNITY COLLEGE

# Kirkwood Community College Insurance Change Form

Effective Date of Change: ___ / ___ / 20____
Event Date: ___ / ___ / 20____
Coverage End Date (if dropping members): ___ / ___ / 20____

**Employee Information** *(Your name must match the way it is reflected on your IRS tax return)*

| First Name: | MI: | Last Name: | Kirkwood k#: |
|---|---|---|---|
| Marital Status: ☐ Single ☐ Married ☐ Common Law/Domestic Partner | ☐ Male ☐ Female | Date of Birth: ___/___/__ __ __ __ | SSN: |
| Address: | City: | State: | Zip: |
| Phone Number: | Email Address: | | Date of Hire: ___/___/__ __ __ __ |

**Qualifying Event** (See reverse side for qualifying events)

| | | | |
|---|---|---|---|
| ☐ Marriage/Qualified Domestic Partner | ☐ Divorce/Legal Separation | ☐ Change in Spouse/Partner/Dependent Child Employment | ☐ Other: |
| ☐ Birth/Adoption | ☐ Death | ☐ Dependent Child reaches maximum age | |

**Currently enrolled in:** ☐ PPO Premier (74007-0001) ☐ PPO Choice (74007-1000) ☐ HMO Essential (92400-0000)

**As a result of the qualifying event noted above, please indicate how your coverage levels will change or if no change (for example if you are currently enrolled in family coverage and adding a new baby, mark "No change"):**

| Medical Plan Change | | Dental Plan Change | | Vision Plan Change | |
|---|---|---|---|---|---|
| **From:** | **To:** | **From:** | **To:** | **From:** | **To:** |
| ☐ Employee Only | ☐ Employee Only | ☐ Employee Only | ☐ Employee Only | ☐ Employee Only | ☐ Employee Only |
| ☐ Employee+Spouse/Partner | ☐ Employee+Spouse/Partner | ☐ Employee+1 | ☐ Employee+1 | ☐ Family | ☐ Family |
| ☐ Employee+Child(ren) | ☐ Employee+Child(ren) | ☐ Family | ☐ Family | | ☐ No Change |
| ☐ Family | ☐ Family | | ☐ No Change | | |
| | ☐ No Change | | | | |

**Please list all individuals who should be covered under the medical, dental, and/or vision plans and note in the "Enroll individual in" column the plans in which they should be covered (for example if you are currently enrolled in family medical, dental and vision and adding a new baby, list all family members and check all boxes under "Enroll Individual in").** If claimed as dependents, spouse/partner and dependent names must match who they are reflected on your IRS tax return.

| Relation to Employee | First Name MI Last Name | Social Security # | k# (if known)[2] | Date of Birth | Gender | Enroll individual in |
|---|---|---|---|---|---|---|
| Spouse/Partner | | | | ___/___/__ __ __ __ | ☐M ☐F | ☐Medical ☐Dental ☐Vision |
| Eligible Child | | | | ___/___/__ __ __ __ | ☐M ☐F | ☐Medical ☐Dental ☐Vision |
| Eligible Child | | | | ___/___/__ __ __ __ | ☐M ☐F | ☐Medical ☐Dental ☐Vision |
| Eligible Child | | | | ___/___/__ __ __ __ | ☐M ☐F | ☐Medical ☐Dental ☐Vision |
| Eligible Child | | | | ___/___/__ __ __ __ | ☐M ☐F | ☐Medical ☐Dental ☐Vision |

[2] *Spouse/Partner and dependents who do not already have a k# will be assigned one in the Kirkwood system. This is required in order to produce the employee's annual IRS Form 1095-C.*

**Medicare Coverage –** If the employee and/or any dependents noted on this application are Medicare enrolled, please complete the following for each:

| | |
|---|---|
| Name of person(s) covered by Medicare: | Effective Date of Part A: |
| Medicare ID Number(s): | Effective Date of Part B: |

**Other Carrier Information -** If the employee and/or any dependents noted above have other Medical and/or Dental coverage, please complete the following:

| | |
|---|---|
| Effective Date of Other **Medical** Coverage: | Effective Date of Other **Dental** Coverage: |
| Employer: | Employer: |
| **Medical** Insurance Company: | **Dental** Insurance Company: |
| **Medical** Plan Policy# or Member ID: | **Dental** Plan Policy# or Member ID: |
| Who is covered: | Who is covered: |

**Employee Acknowledgement/Authorization**

I have read and understand the Authorization/Certification and qualifying event language on the back of this application and acknowledge of a copy of this application.

**Employee Signature:** _____ **Date:** ____/____/__ __ __ __

**FOR HR USE ONLY:**

**Employment Status:**

☐ Full-Time Board Approved (Kirkwood) ☐ Full-Time/Non-Board Approved(Kirkwood) ☐ Retiree (PPO-P 74007-0008)
☐ Full-Time Board Approved (Hotel) ☐ Full-Time/Non-Board Approved (Hotel) ☐ Retiree (PPO-C 74007-1008) ☐ MIIP
☐ Retiree (HMO-E 92400-0008) ☐ PBEN

## Authorization and Certification

I certify below that I have completed this form to the best of my knowledge, and I understand the following:

- I am legally authorized to apply for coverage for myself and all other persons named on this application.
- I understand that I am making application for the coverage sponsored by my employer or group sponsor.
- My coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying change in status (see below below). I may, however, change my coverage elections during the next open enrollment period provided I am still eligible to participate in the group plan.
- My pay will be reduced by the amount of any required contributions noted for the coverages elected, collected in advance on a pre-tax basis and remitted to the plans on by behalf.
- I acknowledge receiving a copy of the Summary of Benefits and Coverage (SBC) and reading the descriptions of the benefit plans in which I am enrolling. I also understand any limitations or restrictions on coverage or benefits under these benefit plans as described in the SBC and carrier Benefit Certificates.
- All statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage and/or criminal charges.
- I give permission to the health plan administrator (Wellmark Blue Cross Blue Shield of Iowa and Wellmark Health Plan of Iowa) to obtain and/or examine my medical records (and/or those of my dependent(s)) from any health care practitioner or institution in which care is provided while a member, to the extent permitted by law.
- This form does not authorize the redisclosure of medical information.
- I authorize my health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental care coverage for which I have applied.
- Unless noted, the enrollment period for any qualifying event is within 30 days of the occurrence of the event. Enrolling in or dropping of an individual policy is not a qualifying event.

**HIPAA Special Enrollment Rights:** HIPAA allows the active employee who may have elected employee only coverage initially to not only add a new dependent, but also allows the employee to add the spouse at the time the new dependent is added. HIPAA does not require that all eligible dependents (i.e., other dependent children) be added. Retiree: See MIIP Eligibility Rules for qualifying events.

*Loss of eligibility for group coverage under another employer/group plan due to:*

- Divorce/annulment/dissolution of marriage or legal separation
- Termination of employment
- Loss of dependent status
- Group health plan is no longer offered to any employees
- Death
- Reduction in work hours to the point that health plan coverage is lost
- Move outside of the HMO's service area
- Group health plan is not offered to certain groups of employees (such as part-time employees)

*Life Events:*

- Marriage
- Adoption or placement for adoption of a child
- Birth of a child (60 day period to enroll)

*Loss of eligibility or premium assistance under a state or federal program such as:*

- Title XIX/Hawk-I program (or any other state CHIP program) (60 day period to enroll)

Medicaid (60 day period to enroll)

**Section 125 Qualifying Events**: In addition to the above HIPPA events, the following Section 125 qualifying events also allow for changes in employee benefit elections during the plan year. Retirees: See MIIP Eligibility Rules for qualifying events.

*Change in Employment Status for an employee, spouse/partner or dependent:*

- Termination of employment
- Commencement or return from a leave of absence
- Commencement of employment
- Change in employment class resulting in eligibility for/loss of eligibility for group coverage

*Changes in Cost or Coverage*

- Significant cost changes in employee contributions for a benefit option
- Change in coverage under another employer plan (spouse/partner's plan enrollment period does not coincide with employee's enrollment period)
- Enrollment into a Qualified Health Plan through the Healthcare Marketplace/ Exchange (loss of such coverage is NOT a qualifying event to enroll in our plan).

## Waiver of Coverage
## Full-time Non Board-Approved Staff (Truck Driving Instructors, Hotel Full-Time)

I understand that I am in an employee status whose enrollment in the medical, dental and/or vision coverage requires an employee contribution toward single coverage (as well as paying the full cost toward coverage for family members) and as a result, I may waive coverage for the medical, dental and/or vision. I have indicated on the reverse side of this form the plans and coverage levels in which I would like to enroll, if any, and indicated below the plans in which I would like to waive coverage.

| I wish to waive coverage for myself and/or my dependents for: | ☐ Medical | ☐ Dental | ☐ Vision |
|---|---|---|---|

I have read and understand the Authorization and Certification and Waiver of Coverage information and I wish to waive coverage as noted above.

**Employee Signature:** _____ **Date:** _____

**Employee Name (please print):** _____ **k#:** _____

**Department:** _____