THIS FORM MUST BE SUBMITTED TO YOUR HR/PAYROLL CLERK. DO NOT SUBMIT DIRECTLY TO MUST

CHANGE FORM FOR 2009-10

(Effective July 1, 2009)

ADMINISTRATIVE USE ONLY:
Received by School District Clerk: Date ____/____/____ init ______
Entered by MUST: Date___/____/____ Notes:___________________

School District Name ____ Group Number #: ___________

Indicate Type of Change Below **Effective Date of This Change: _______________**

NAME – Please indicate YOUR PRIOR name so we can correctly identify you: _____________________________

ADDRESS CHANGE ADD COVERAGE ADD DEPENDENT DROP COVERAGE DROP DEPENDENT

STATUS CHANGED TO RETIRED CHANGE OF BENEFICIARY PLAN CHANGE W/ SPECIAL ENROLLMENT

EMPLOYEE INFORMATION (REQUIRED):

Employee First Name, Middle Initial	**Employee Last Name**		**Social Security Number**	
Address	City	State	Zip	Telephone

CHANGE MY ENROLLMENT AS INDICATED BELOW :

First Name, Last Name	Sex	Social Security #	Date of Birth	Relationship	*IRS Tax Dependent Yes or No	Medical		Dental		Vision	
						Add	**Drop**	**Add**	**Drop**	**Add**	**Drop**

***Please review the Senate Bill 419 and Possible Tax Consequences Form.**

CHANGE OF BENEFICIARY

Name	Address	Soc. Sec. No.	Relationship	% of Benefit

REASON FOR ADD/CHANGE (indicate below)	**DATE OF EVENT**			**REASON FOR DROP** (indicate below)	**DATE OF EVENT**		
Newborn (Provide other parent's DOB to determine coordination of benefits) Other Parent's DOB:____________________				**Divorce or Legal Separation** (Provide address for COBRA notice)			
Adoption / Court Order (attach proof)				**Ineligible Dependent** Reason: ______________________			
Marriage (date of marriage required)				**Waiving Health Benefit** (Complete waiver form on the back)			
Retired: (You must provide Teachers' Retirement or Public Employees' Systems documentation)*				**Death**			
Loss of Other Coverage (You must provide a Certificate of Creditable Coverage)				**Other:**			

Plan Change: From: _________________ _________________
Note: Plan Changes only apply to Special Enrollment Events (Old Plan Name) to (New Plan Name)

***Retiree must complete for Life Insurance** ❒ YES, I wish to continue my life insurance
❒ NO, I do not wish to continue my life insurance

REQUIRED **OTHER INSURANCE INFORMATION:** Do you, your spouse or your children have other medical, dental or vision insurance? ❒ YES ❒ NO If you answered yes, please provide the required information below.

		EMPLOYER NAME, INSURANCE CARRIER NAME & ADDRESS	TYPE OF COVERAGE
SELF: ❒ YES ❒ NO			❒ MED ❒ DEN ❒VIS
SPOUSE: ❒ YES ❒ NO			❒ MED ❒ DEN ❒ VIS
CHILDREN (LIST)	❒ YES ❒ NO		❒ MED ❒ DEN ❒ VIS
	❒ YES ❒ NO		❒ MED ❒ DEN ❒ VIS
	❒ YES ❒ NO		❒ MED ❒ DEN ❒ VIS

____ ______________________

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

HEALTH COVERAGE WAIVER FORM

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

Group Name	Group Number
Employee Name (FIRST) (MI) (LAST)	Employee's Social Security Number

I decline to enroll with MUST medical coverage for: ☐ **Myself** ☐ **My Dependent Family Members**

☐ **My Newborn Child** : Name ___________________________ Date of Birth:____________________ Gender:____________

***Important for Newborns: Your baby will have 31 days of automatic coverage. If the baby's other parent is not enrolled on your plan please indicate his/her name, Date of Birth, and the name of their insurance carrier to determine which plan is primary for the first 31 days of coverage per the birthday rule.**

Other Parent's Name:______________________ DOB:__________ Other Carrier:_______________________

Reason for waiver: ☐ the existence of other coverage
☐ other reason (explain) ____

l.__________________________________ 3. __________________________________ 5. __________________________________

2.__________________________________ 4. __________________________________ 6. __________________________________

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, as that term is defined below. **I am also waiving the Basic Standard Life Insurance offered with the plan.** This does not include employees provided Medical coverage under their spouse's MUST benefits. **The Long Term Disability Benefit (LTD) provided by the plan is waived as well**. **Only members with medical coverage are eligible for the LTD benefit.**

____

SIGNATURE OF APPLICANT DATE

NOTICES

Special Enrollment Periods. If you are waiving coverage for yourself or your eligible dependents as defined by your Plan (including your spouse) because you or they are currently covered under other health insurance or another health care plan, you may be able to enroll yourself or your dependents for coverage under this plan in the future, provided that you request such coverage within thirty (30) days after such other coverage ends. 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.

Also, if you acquire an eligible dependent, as defined by your Plan, as a result of marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll yourself and your newly acquired dependent children or spouse for coverage under this Plan, provided that you request such coverage within thirty (30) days after marriage, birth, adoption or placement for adoption. An application for coverage must be received in the MUST office within 60 days of the event. Please refer to your Summary Plan Description for more detailed information.

Pre-existing Condition Exclusion. This health benefit plan may exclude certain medical conditions (either physical or mental) from coverage, if you or an eligible dependent received medical advice, diagnosis, treatment or care for that condition, including prescription medication, within a six (6) month period immediately preceding your enrollment date under this health benefit plan. The enrollment date means the date you or your dependent becomes eligible for coverage under this Plan. The plan will only apply the exclusion to Late Enrollees.

Such pre-existing conditions may be excluded from coverage for a period of eighteen (18) consecutive months beginning on your enrollment date. ***For information specifying the exact time periods referred to in this notice, consult your Plan Administrator, employer, or Summary Plan Description.***

Creditable Coverage. You or your eligible dependent, as defined by this Plan, may submit to the Plan Administrator, certification of Creditable Coverage from any prior health insurance or health care plan under which you or your eligible dependent had coverage, for the purpose of reducing, on a day-for-day basis, the pre-existing condition exclusion imposed by this Plan for any pre-existing condition for which you or your eligible dependent had applicable Creditable Coverage.

You or your eligible dependent have a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which you or your eligible dependent had coverage.

If you are unable to obtain a Certificate of Creditable Coverage from your prior insurance carrier or health plan, the Plan Administrator will provide assistance to obtain the same from your prior carrier or health plan. The Plan also has written procedures to determine Creditable Coverage if you are unable to obtain a Certificate of Creditable Coverage. Please consult the Plan Administrator for more information regarding this procedure.

"Creditable Coverage" means health or medical coverage under which you or your eligible dependent was covered, prior to your enrollment date under this Plan, which prior coverage was under any of the following:

1. A group health Plan
2. Health insurance coverage
3. Part A or Part B of Title XVII of the Social Security Act
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928
5. Chapter 55 of Title 10, United States Code
6. A medical care program of the Indian Health Service or a tribal organization
7. A state health benefits risk pool
8. A health plan offered under Chapter 89 of Title 8, United States Code.
9. A public health plan including a nationalized health plan of a foreign country
10. A health benefit plan under Section 5(e) of the Peace Corps Act

l l. State Children's Health Insurance Program

Creditable Coverage for which there has not been a break exceeding sixty-three (63) days prior to a Covered Person's effective date of coverage under this Plan, shall be credited on a day-for-day basis against any pre-existing condition exclusion imposed by the terms of this Plan provided that the prior creditable coverage included coverage for the excluded condition. A **"Certificate of Creditable Coverage"** must include the following information in order for us to determine the exact number of days to be reduced from the **pre-existing condition exclusionary period**.

1. The name or names of the individuals who were previously covered.
2. The date the previous health coverage began.
3. The date the previous health coverage ended.

INSURANCE ID CARDS AND OTHER LIKE DOCUMENTS CANNOT BE ACCEPTED IN LIEU OF CERTIFICATES OF CREDITABLE COVERAGE BUT MAY BE USED AS EVIDENCE OF ANY PRIOR COVERAGE.

All questions about the Pre-existing Condition Exclusion and Creditable Coverage should be directed to a MUST ENROLLMENT SPECIALIST at 1-800-845-7283.

Change form revised 02/09