# Montana Automobile Dealers Insurance Trust

*HEALTH INSURANCE ENROLLMENT/CHANGE/TERM FORM*

**SELF ENROLL MEMBERS ONLY**

***Please use this form form for all new hires, changes and terms - DO NOT EMAIL - FAX ONLY TO 449-0119***

| Last Name | First Name | Initial | Home/Cell Phone |
|---|---|---|---|
| | | | |

| Current Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Employer: | Occupation: | Group Number: 700 |
|---|---|---|
| | | |

***SECTION 1 ~ Please fill out the section below that applies to a new enrollment, enrollment changes or termination of coverage***

## *Part A - New Enrollment*

Effective Date of Coverage: ______________________________

First Day of Work: _________________ Hours worked per week: __________________

**Enrollment reason:** ☺ Initially Eligible ☺ Transfer ☺ QE ☺ Open Enrollment

**Marital Status:** ☺ Single ☺ Married ☺ Divorced ☺ Widowed ☺ Separated

***Medical Plan Choice - Please check only one appropriate box below:***

☺ Trad 70/30 ☺ Trad 60/40 ☺ Trad 50/50 ☺ HDHP 2700 ☺ HDHP 4500

## *Part B - Enrollment Changes*

| | Qualifying Event Date |
|---|---|
| **Marriage/Divorce: (circle one)** | |
| | |
| **Birth/Adoption: (circle one)** | |
| | |
| **Ineligible Dependent: (name)** | |
| | |
| **Address Change (new address):** | |
| | |

***Medical Plan Choice - Qualifying Events Only - check only one below***

☺ Trad 70/30 ☺ Trad 60/40 ☺ Trad 50/50 ☺ HDHP 2700 ☺ HDHP 4500

***Must provide supporting legal documentation of divorce, marriage, adoption, etc.***

***Notes:*** *Use this space for clarification on any of the above*

## *Part C - Termination of Coverage*

**Last day worked** ____________________

☺ Voluntary by employee ☺ Involuntary by employer

**Qualifying Event** (Term, Resignation, Reduce Hrs, Death): ____________________________

***Coverage will end the last day of the month in which employee was terminated.***

***SECTION 2 ~ CHECK ONLY BOXES THAT APPLY TO CURRENT CHANGE(S) OR NEW ENROLLMENT*** ***Note: Your group may not offer all coverages listed***

| FIRST MI LAST<br>*New enrollee - must complete employee info also* | SOCIAL SECURITY # (Required) | DATE OF BIRTH | RELATIONSHIP | Sex | Medical | | Vision | | Delta Dental | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Add | Drop | Add | Drop | Add | Drop |
| **Employee:** | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Spouse: | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Child(ren): (list) | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**PARTICIPATION CERTIFICATION:** **I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS FOR THE COST OF BENEFITS FOR WHICH I AM OR MAY BECOME ELIGIBLE.**

**I acknowledge that coverage has been offered to me and I elect not to participate at this time because:**

**WAIVER OF PARTICIPATION** ____________________________________________

Employee Signature: ______________________________ Date ______________

Participant's Signature: ______________________________ Date: ______________

Employer's Signature: ______________________________ Date: ______________

Rev 12.16.15