Delaware Valley Health Insurance Trust New Hire/Termination/Change Form

A. Employee Information-Please read, fill in the entire form and sign. Please print clearly.

Public Entity	Last name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one) Single ❑ Married ❑ Divorced/Separated ❑

Department	Home Street Address	Apt #	City	State	ZIP Code

Home Telephone	Work Telephone	Email address (if available)	Hours worked per week

❑ **New Hire:** Effective Date ________________ Hire Date ________________ ❑ **Change in Coverage:** Effective Date ________________ **Type of Event:** ________________________

❑ **Change of Address:** Effective Date __________________ ❑ **Name Change:** Effective Date: ________________ Change Name To: ______________________________

❑ **Termination:** Effective Date ___________________ **Offer COBRA**: ❑ Yes - COBRA Qualifying Event Date: ___________________ ❑ No - Reason _______________________________

COBRA Qualifying Event Type:

Member: ❑ Voluntary Termination ❑ Retirement ❑ Resignation ❑ Involuntary Termination (Other than Gross Misconduct) ❑ Reduction of Hours ❑ Military Leave

Dependent: ❑ Divorce or Legal Separation ❑ Dependent No Longer Eligible ❑ Death of covered member ❑ Employee Medicare Eligible (this is rare)

DEPENDENT ADDRESS: *If dependent lives at a different address please note name of dependent and provide his/her address:*

B. Individuals Covered - List individuals for whom you are requesting coverage/change. For additional children, please attach another sheet.

	Last name, First name, M.I.	**(A)dd (C)hange (R)emove**	**Gender M**	**F**	**Date of Birth**	**Social Security Number**	**Check if dependent is a Full-Time Student (FTS) or Dependent with a Disability (D)**		***HMO/QPOS* Primary Care Physician Info**		
									Primary Office Number (6 digits or less)	**Primary Care Physician Name (Last Name, First Name)**	**Office Location** (city &/or zip code)
Self			❑	❑							
Spouse			❑	❑			**FTS**	**D**			
Child			❑	❑			❑	❑			
Child			❑	❑			❑	❑			
Child			❑	❑			❑	❑			

C. Plan Option & Coverage Level Selection –Select coverage level

Medical Plan Selection (select one)		**Plan co-pay**	**Medical Coverage Level** (select one)		**Dental Coverage Level** (select one)	
HMO	❑		Employee Only	❑	Employee Only	❑
QPOS	❑		Employee and Spouse	❑	Employee and Spouse	❑
Choice POS II (Open Access)	❑		Employee and Child	❑	Employee and Child	❑
Open Choice PPO	❑		Employee and Children	❑	Employee and Children	❑
Indemnity	❑		Family	❑	Family	❑

E. Other Insurance Information: ❑ **No** ❑ **Yes** If yes for any family member, please provide a photocopy of insurance card

F. Employee Signature I represent that all the information supplied on this form is true and complete. I hereby agree to the Terms and Conditions (page 2).

Employee Signature – Required X **Date:** / /20	**Employer Verification** X **Date:** / /20

Terms and Conditions

By signing this form you agree to abide by the following:

Dependents can only be added or deleted mid-year if a family status change occurs which is consistent with the benefits change that is being made. You must notify your employer **within 30 days** of the event. If you fail to notify your employer, you must wait until the next open enrollment period. Family status changes include marriage, divorce, legal separation, the birth or adoption of a child, ineligibility of a dependent, or a change in employment status (for you, your spouse or dependent) such as a leave of absence without salary, a job termination or new job commencement.

To Add a Dependent to Your Current Coverage

In order to add an eligible dependent to your current coverage, you must follow the enrollment rules listed below. The federal Mandatory Insurer Reporting Law (Section 111 of Public Law 100-173) requires group health plans to report to Medicare the Social Security Numbers of members covered under an insurance plan. To ensure your enrollment and compliance with this new law, please provide this information. For more information on the mandatory reporting under this law, please see www.cms.hhs.gov/MandatoryInsRep/.

Marriage

To be covered, your new spouse must be added to your coverage within 30 days of your date of marriage. The effective date of coverage will be retroactive to the date of marriage.

Birth

Your new child must be added to your coverage within 30 days of the date of birth. The effective date of coverage will be retroactive to the date of birth.

Adoption

Your adopted child must be added to your coverage within 30 days of the adoption. Coverage will be effective on the date of the adoption. DVHIT and/or your employer must verify the date of adoption by reviewing the adoption documentation. For U.S. adoptions, attach the court signed petition for adoption or adoption decree. For international adoptions, attach a copy of the visa or passport page that identifies the date of U.S. entry and a copy of the adoption orders signed by a magistrate or other government official.

Legal Guardianship

When you accept legal guardianship of a child, the child should be added to your coverage within 30 days of the date the petition is signed by the court. A copy of the signed court order must be provided to your employer and/or DVHIT for review. Coverage becomes effective on the date the court order is effective, or on the date the child moves into your home, whichever is later.

Stepchildren

Your never married stepchildren, in the custody of and legally dependent upon your spouse, who are members of your household, can be added to your coverage within 30 days of the date of marriage. Coverage becomes effective on the date of your marriage.

Your stepchildren who do not satisfy the above eligibility requirements at the time of your marriage and later become eligible due to a change in residence or tax exemption status must be added to your coverage within 30 days of becoming newly eligible. Coverage becomes effective on the date eligibility requirements are met. Documentation may be required.

To Delete a Dependent from Your Current Coverage

Death of a Dependent

Provide the date of death of the dependent on this form.

Job Commencement, Job Change of Dependent with Benefit Eligibility, or Spouse's Open Enrollment

If your spouse or dependent becomes eligible for benefits through their employer or has Open Enrollment, you may remove them from your benefits. They must be removed within 30 days of the coverage effective date under the other plan. You may remove them only from those benefits in which they actually newly enroll (i.e., you may not remove your dependent from your dental coverage if the dependent newly enrolls in medical coverage only). Coverage will be cancelled the first of the month following the month in which they are newly eligible.

Release of Information

DVHIT will not release any information about you except:

1) when you request it in writing, or
2) when the release is necessary to process or review a claim (for example, to another insurance company).

If requested to do so, DVHIT will notify you of the information released and to whom.

Authorization

You authorize any doctor, hospital or other provider rendering service to you or your dependents to furnish to the plan you have selected on this application any information requested concerning medical information, claims and other insurance payments.

Requested Documentation

DVHIT/your employer reserve the right to require proof of dependency upon request. When you sign this form, you agree to provide such documentation upon request.

Waiver of Insurance Coverage Notice of Special Enrollment Period

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health insurance coverage, or if you lose coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, or adoption.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental coverage and you fail to fill out the front of this form concerning your (and/or your eligible dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.

QUESTIONS?

If you have any questions, please contact your HR or benefits department or DVHIT directly:

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719 Dresher Road
Horsham, PA 19044
Phone (215) 706-0101
Fax: (215) 706-0942