Collier County

Health Enrollment Form

Complete all sections below for new enrollments

Incomplete forms will be returned. Please review the Statement of HIPAA Portability Rights on Page 2.

COMPANY / EMPLOYER

COMPANY / EMPLOYER: Collier County Government

GROUP NUMBER: 2003021

EMPLOYEE INFORMATION

FIRST NAME | **MI** | **LAST NAME**

SEX (M/F) | **BIRTH DATE** | **SOCIAL SECURITY NO.** | **DATE OF HIRE**

ADDRESS

CITY | **STATE** | **ZIP**

HOME PHONE | **WORK PHONE** | **E-MAIL**

OCCUPATION / JOB TITLE | **EARNINGS (IF APPLICABLE)**

MARITAL STATUS

⚠ **Fraud Alert:** Misrepresenting marital status or providing false information may be considered health care fraud.

◯ Single ◯ Married ◯ Divorced ◯ Widowed

DEPENDENTS

FIRST	MI	LAST	SSN	BIRTH DATE	SEX	RELATIONSHIP	MED	DENT
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

⚠ **Fraud Notice:** Providing inaccurate information may be considered health care fraud.

SIGNATURE OF APPLICANT _____ DATE _____

If you are adding your spouse
"To your Health Insurance"

Enter their email address:_____

And their phone number:_____

Collier County

Health Coverage Waiver Form

Complete waiver only if waiving coverage for yourself and/or any dependent

WAIVER INFORMATION

COMPANY / EMPLOYER NAME

Collier County Government

GROUP NUMBER

2003021

LAST NAME

FIRST NAME

MI

SOCIAL SECURITY NUMBER

COVERAGE DECLINED

☐ Myself ☐ My Spouse ☐ My Dependent Child/Children

DEPENDENT CHILDREN NAMES

REASON FOR WAIVER

☐ Existence of other coverage

PLAN NAME (IF OTHER COVERAGE)

OTHER REASON (EXPLAIN)

This waiver may affect the ability of each listed person to obtain coverage at a later date.

EMPLOYEE'S SIGNATURE

DATE SIGNED

Statement of HIPAA Portability Rights

Right to special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

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 SHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Collier County

Other Health Insurance Information

Complete if you or your dependents have coverage through another carrier

OTHER HEALTH COVERAGE

◯ Yes (complete below) ◯ No

Check coverage being provided elsewhere:

☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision

FAMILY MEMBERS WITH OTHER COVERAGE

SELF	SPOUSE	CHILD(REN)
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP	DATE COVERAGE WILL END

OTHER INSURANCE COMPANY DETAILS

NAME, PHONE NUMBER & ADDRESS OF INSURANCE COMPANY

POLICY / CERTIFICATE NUMBER | **EFFECTIVE DATE** | **POLICYHOLDER'S NAME**

SOCIAL SECURITY NUMBER | **DATE OF BIRTH**

If enrolled in Medicare Part A, B, or D, or Medicaid:

ENROLLEE'S NAME(S):	MEDICARE OR MEDICAID ID#:	MEDICARE PART A EFFECTIVE DATE:	MEDICARE PART B EFFECTIVE DATE:	MEDICARE PART D EFFECTIVE DATE:	MEDICAID EFFECTIVE DATE:

CUSTODY & DIVORCE INFORMATION

⚠ If parents were never married or are separated/divorced, complete below to determine primary liability.

DATE OF DIVORCE / SEPARATION

COURT ORDER FOR MEDICAL EXPENSES? ◯ Yes ◯ No

**If yes, provide copy of divorce decree or parenting plan.*

PARENT WITH PHYSICAL CUSTODY

DOB OF CUSTODIAL PARENT

HAS CUSTODIAL PARENT REMARRIED? ◯ Yes ◯ No

DOES STEP-PARENT COVER CHILD? ◯ Yes ◯ No

STEP-PARENT INSURANCE COMPANY, PHONE & ADDRESS

POLICYHOLDER'S NAME | **POLICYHOLDER'S DOB** | **POLICY / CERTIFICATE NUMBER**

EFFECTIVE DATE

TERMINATION DATE (IF APPLICABLE)

COVERAGE TYPE:

☐ Medical ☐ Prescription ☐ Dental ☐ Vision

MEMBERS ON THE PLAN