maestro health™
Working together. For your benefit(s).

Union county #254

GROUP BENEFIT ENROLLMENT FORM and CHANGE FORM

SHADED AREAS FOR HUMAN RESOURCES USE ONLY

DATE OF HIRE:	LOCATION:	EFF. DATE OF CHANGE:

EXPLANATION: ☐ NEW ENROLLMENT ☐ PLAN OPTION CHANGE ☐ ADD/REMOVE DEPENDENTS ☐ TERMINATION
☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ OTHER: ____________________________________

1. EMPLOYEE PROFILE

Employee Name		***Employee ID #***	
Maestro Member ID #		***Social Security #***	
Street Address		***Date of Birth***	
City, State, Zip		***Home Phone #***	
Email Address (Required)		***Gender:***	☐ Male ☐ Female
Marital Status	SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐		

2. COVERAGE ELECTION SECTION

	MEDICAL PLAN	***DENTAL PLAN***	***Plan Option*** *(choose one)*
Coverage Level	**Indicate with "X"**	**Indicate with "X"**	
Employee Only			☐ Direct Primary Care ☐ Traditional
*Employee + Spouse**			
Employee + Child(ren)			
*Employee + Family**			
WAIVE COVERAGE	Initial here to **decline medical** coverage _______________	Initial here to **decline dental** coverage _______________	

* PLEASE NOTE – If your spouse is eligible to participate in a group health plan through his/her employer, he/she is NOT eligible to participate in either the Union County Employee or Retiree Health Plan. This applies whether or not he/she chooses to enroll in his/her employer's health plan.

3. DEPENDENT INFORMATION

To be covered, all dependents must be listed below; Dependents not named are not covered. Dependents are not eligible if employee coverage is not elected. Indicate: a dependent child who is handicapped; a dependent who has any other insurance; and a dependent child who is covered by you due to a QMSCO (Qualified Medical Child Support Order.)

Dependent Name *(X) indicates a change to this member's information*	**Dep. Soc.Sec. # (Must be provided for all dependents)**	**Date of Birth (mm/dd/yyyy)**	**Medical/Dental Coverage Indicate (Add or Drop)**	**Dependent Rel. to you (son, wife, etc)**	**Disabled? (Y or N)**	**Is other insurance available (Y or N)**	**QMCSO? (Y or N)**
( )							
( )							
( )							
( )							
( )							

4. SPOUSE EMPLOYMENT QUESTIONNAIRE (You must complete if covering your spouse under this Plan)

Coverage question		Special instructions
Is your spouse currently employed?	**Yes** ☐ **No** ☐	**If Yes, please complete following information. If No, please continue to Section 5 of the form.**
Do you and your spouse have the same employer?	**Yes** ☐ **No** ☐	
Spouse Employer Name	**Employment Date**	**Phone Number**
Address		
If employed, does your spouse's employer offer a health plan?	**Yes** ☐ **No** ☐	
Is your spouse currently participating in his/her employer's health plan?	**Yes** ☐ **No** ☐	**If No, please complete section below.**

Please check the appropriate option regarding your Spouse's health plan options:

☐ The employee does not have access to coverage because his/her employer does not offer a health plan.

☐ The employee does not have access to coverage because he/she is Part Time.

☐ The employee does not have access to coverage because he/she is still in their waiting period. Date eligible to enroll for coverage: ____/____/____

5. ENROLLEE ACKNOWLEDGEMENT SECTION

Initial Below	*PLEASE CAREFULLY READ the acknowledgement below and initial in the left column.*
LINE A	*I acknowledge that I have read and fully understand the ENROLLMENT DISCLOSURE NOTICE. I further acknowledge that I have reviewed a copy of the Summary Plan Description and understand that a copy of the Summary Plan Description will be provided to me.*
LINE B	*I acknowledge that I must notify the Human Resources Department within 30 days of a Qualifying Event in order to change coverage status due to the Qualifying Event. I also acknowledge that I fully understand the provisions for Late Enrollment under this plan and Open Enrollment under this Plan.*
LINE C	*I acknowledge that I fully understand the applicable cost to me for each group benefit plan and how participation in this Plan will affect my weekly "take-home" pay. I also acknowledge that I fully understand coverage, exclusions, and the provisions for adding or dropping coverage for myself and/or my dependents.*
LINE D	*I acknowledge and understand that my spouse's employment status effects eligibility under my group health plan. I further acknowledge that I am responsible for communicating changes in my spouse's employment to my employer.*
LINE E	*I acknowledge and understand the Plan Declaration shown below.*

Employee Signature: | *Date:*

INDICATION OF THE QUALIFYING CHANGE IN FAMILY STATUS

Qualifying Change in Family Status *(must check one if this is a Special Enrollment Change Form)*
Qualifying Event Date: _____/_____/_______

Qualifying Event Description	**Human Resources use only**
❑ Marriage; ❑ Divorce or Legal Separation; ❑ Death of a spouse or child; ❑ Birth or adoption of a child; ❑ Termination of your spouse's employment; ❑ Commencement of your spouse's employment; ❑ Change from part-time to full-time, or vice versa, by you or your spouse; ❑ The taking of an unpaid leave of absence by either you or your spouse; ❑ A significant change in your health coverage or your spouse's health coverage attributable to your spouse's job; ❑ Enrollment in Market Place Coverage ❑ Open Enrollment	