



Kirkwood Community College Insurance Change Form

Effective Date of Change: _____

Date of Qualifying Event: _____

Employee Information			
First Name:	MI:	Last Name:	Kirkwood k#:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law/Domestic Partner		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Address:		City:	State:
Phone Number:		Email Address:	Date of Hire:
SSN:			
Zip:			

Qualifying Event			
<input type="checkbox"/> Marriage/Qualified Domestic Partner	<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Change in Spouse/Partner/Dependent Child Employment	<input type="checkbox"/> Other:
<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Death	<input type="checkbox"/> Dependent Child reaches maximum age	<input type="checkbox"/> Annual Open Enrollment

Currently enrolled in:	<input type="checkbox"/> PPO Premier (74007-0001)	<input type="checkbox"/> PPO Choice (74007-1000)	<input type="checkbox"/> HMO Essential ¹ (92400-0000)
Change to (during open enrollment only):	<input type="checkbox"/> PPO Premier (74007-0001)	<input type="checkbox"/> PPO Choice (74007-1000)	<input type="checkbox"/> HMO Essential ¹ (92400-0000)

¹ If you are adding individuals to the HMO plan, you must also complete a new Primary Care Provider Selection form. During Annual Open Enrollment, if you are adding family members to the medical plan, you must enroll in the HMO Essential Plan.

As a result of the qualifying event noted above, please indicate how your coverage levels will change or if no change (for example if you are currently enrolled in family coverage and adding a new baby, mark "No change"):

Medical Plan Change		Dental Plan Change		Vision Plan Change	
From:	To:	From:	To:	From:	To:
Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only
Employee+Spouse/Partner	<input type="checkbox"/> Employee+Spouse/Partner	<input type="checkbox"/> Employee+1	<input type="checkbox"/> Employee+1	<input type="checkbox"/> Family	<input type="checkbox"/> Family
Employee+Child(ren)	<input type="checkbox"/> Employee+Child(ren)	<input type="checkbox"/> Family	<input type="checkbox"/> Family		No Change
Family	<input type="checkbox"/> Family		No Change		
	No Change				

Please list all individuals who should be covered under the medical, dental, and/or vision plans and note in the "Enroll individual in" column the plans in which they should be covered (for example if you are currently enrolled in family medical, dental and vision and adding a new baby, list all family members and check all boxes under "Enroll Individual in"):

Relation to Employee	First Name	MI	Last Name	Social Security #	k# (if known) ²	Date of Birth	Gender	Enroll individual in
Spouse/Partner							<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Eligible Child							<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Eligible Child							<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Eligible Child							<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Eligible Child							<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

² Spouse/Partner and dependents who do not already have a k# will be assigned one in the Kirkwood system. This is required in order to produce the employee's annual IRS Form 1095-C.

Medicare Coverage – If the employee and/or any dependents noted on this application are Medicare enrolled, please complete the following for each:	
Name of person(s) covered by Medicare:	Effective Date of Part A:
Medicare ID Number(s):	Effective Date of Part B:

Other Carrier Information - If the employee and/or any dependents noted above have other Medical and/or Dental coverage, please complete the following:	
Effective Date of Other Medical Coverage:	Effective Date of Other Dental Coverage:
Employer:	Employer:
Medical Insurance Company:	Dental Insurance Company:
Medical Plan Policy# or Member ID:	Dental Plan Policy# or Member ID:
Who is covered:	Who is covered:

Employee Acknowledgement/Authorization

I have read and understand the Authorization/Certification and qualifying event language on the back of this application and acknowledge of a copy of this application.

Employee Signature: _____ Date: _____

FOR HR USE ONLY:

Employment Status:	<input type="checkbox"/> Full-Time Board Approved (Kirkwood)	<input type="checkbox"/> Full-Time/Non-Board Approved(Kirkwood)	<input type="checkbox"/> Retiree (PPO-P 74007-0008)
	<input type="checkbox"/> Full-Time Board Approved (Hotel)	<input type="checkbox"/> Full-Time/Non-Board Approved (Hotel)	<input type="checkbox"/> Retiree (PPO-C 74007-1008) <input type="checkbox"/> MIIP
			<input type="checkbox"/> Retiree (HMO-E 92400-0008) <input type="checkbox"/> PBEN

Authorization and Certification

I certify below that I have completed this form to the best of my knowledge, and I understand the following:

- I am legally authorized to apply for coverage for myself and all other persons named on this application.
- I understand that I am making application for the coverage sponsored by my employer or group sponsor.
- My coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying change in status (see below below). I may, however, change my coverage elections during the next open enrollment period provided I am still eligible to participate in the group plan.
- My pay will be reduced by the amount of any required contributions noted for the coverages elected, collected in advance on a pre-tax basis and remitted to the plans on my behalf.
- I acknowledge receiving a copy of the Summary of Benefits and Coverage (SBC) and reading the descriptions of the benefit plans in which I am enrolling. I also understand any limitations or restrictions on coverage or benefits under these benefit plans as described in the SBC and carrier Benefit Certificates.
- All statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage and/or criminal charges.
- I give permission to the health plan administrator (Wellmark Blue Cross Blue Shield of Iowa and Wellmark Health Plan of Iowa) to obtain and/or examine my medical records (and/or those of my dependent(s)) from any health care practitioner or institution in which care is provided while a member, to the extent permitted by law.
- This form does not authorize the redisclosure of medical information.
- I authorize my health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental care coverage for which I have applied.
- Unless noted, the enrollment period for any qualifying event is within 30 days of the occurrence of the event. Enrolling in or dropping of an individual policy is not a qualifying event.

HIPAA Special Enrollment Rights: HIPAA allows the employee who may have elected employee only coverage initially to not only add a new dependent, but also allows the employee to add the spouse at the time the new dependent is added. HIPAA does not require that all eligible dependents (i.e., other dependent children) be added.

Loss of eligibility for group coverage under another employer/group plan due to:

- | | |
|---|--|
| <ul style="list-style-type: none"> - Divorce/annulment/dissolution of marriage or legal separation - Termination of employment - Loss of dependent status - Group health plan is no longer offered to any employees | <ul style="list-style-type: none"> - Death - Reduction in work hours to the point that health plan coverage is lost - Move outside of the HMO's service area - Group health plan is not offered to certain groups of employees (such as part-time employees) |
|---|--|

Life Events:

- | | |
|---|--|
| <ul style="list-style-type: none"> - Marriage - Adoption or placement for adoption of a child | <ul style="list-style-type: none"> - Birth of a child (60 day period to enroll) |
|---|--|

Loss of eligibility or premium assistance under a state or federal program such as:

- | | |
|---|--|
| <ul style="list-style-type: none"> - Title XIX/Haw-I program (or any other state CHIP program) (60 day period to enroll) | <ul style="list-style-type: none"> - Medicaid (60 day period to enroll) |
|---|--|

Section 125 Qualifying Events: In addition to the above HIPAA events, the following Section 125 qualifying events also allow for changes in benefit elections during the plan year.

Change in Employment Status for an employee, spouse/partner or dependent:

- | | |
|---|--|
| <ul style="list-style-type: none"> - Termination of employment - Commencement or return from a leave of absence | <ul style="list-style-type: none"> - Commencement of employment - Change in employment class resulting in eligibility for/loss of eligibility for group coverage |
|---|--|

Changes in Cost or Coverage

- | | |
|--|--|
| <ul style="list-style-type: none"> - Significant cost changes in employee contributions for a benefit option - Enrollment into a Qualified Health Plan through the Healthcare Marketplace/Exchange | <ul style="list-style-type: none"> - Change in coverage under another employer plan (spouse/partner's plan enrollment period does not coincide with employee's enrollment period) |
|--|--|

Waiver of Coverage Full-time Non Board-Approved Staff (Truck Driving Instructors, Hotel Full-Time)

I understand that I am in an employee status whose enrollment in the medical, dental and/or vision coverage requires an employee contribution toward single coverage (as well as paying the full cost toward coverage for family members) and as a result, I may waive coverage for the medical, dental and/or vision. I have indicated on the reverse side of this form the plans and coverage levels in which I would like to enroll, if any, and indicated below the plans in which I would like to waive coverage.

I wish to waive coverage for myself and/or my dependents for:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
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I have read and understand the Authorization and Certification and Waiver of Coverage information and I wish to waive coverage as noted above.

Employee Signature: _____ **Date:** _____

Employee Name (please print): _____ **k#:** _____

Department: _____



Kirkwood Community College Primary Care Provider Selection Form For HMO Essential Plan Only

Effective Date: _____

Employee Information			
First Name:	MI:	Last Name:	
Address:			
City/State/Zip:		Social Security Number:	

Provider Information						
	First Name	Last Name	PCP Name	**PCP 5 digit Enrollment ID# (see instructions below)	OB/GYN Name (optional)	OB/GYN 5 digit Enrollment ID#
Employee						
Spouse/ Partner						
Child						
Child						
Child						
Child						
Child						
Child						

** You can verify your provider is in the Blue Advantage network and obtain their Enrollment ID by going to www.wellmark.com, then click on Find a Doctor or Hospital. See example below:

The screenshot illustrates the Wellmark website interface for finding a provider. It shows the search criteria form, the search results for 'Browne, John R, MD', and the detailed provider profile page. Red arrows highlight the 'Plan Help' link, the 'Enrollment ID #' field, and the 'Plans Accepted' list.

Search Criteria:

- PLAN: Coverage Information (I know my plan / I'm just looking)
- My Plan Is... (Blue Advantage (Iowa and Bordering Counties))
- SEARCH CRITERIA: I'm Looking For A... (No Preference, General/Family Practitioner, Specialist, OB/GYN)
- LOCATION: Select Location to Search From (Address, City and State, or Zip Code)

Search Results:

- NAME/ADDRESS: Browne, John R, MD (2.8 mi)
- Mercy Employee Health Center (788 8th Ave SE Ste 204, Cedar Rapids, IA 52401)
- Specialties: Family Practice
- Plans Accepted: Alliance Select, Blue Access, Blue Advantage, Blue Choice, Blue Rewards POS-Tier 2, Classic Blue, Hawk-I Blue Access, Wellmark Blue HMO, Wellmark Blue POS, Wellmark Blue PPO
- Patient Reviews: Overall Patient Rating (5 stars), 100% recommend | 3 ratings

Provider Profile: Browne, John R, MD

- May be both a Primary Care Provider and a Non-Primary Care Provider
- General Information: Mercy Employee Health Center
- Address: 788 8th Ave SE Ste 204, Cedar Rapids, IA 52401, County: Linn, (319) 398-6342
- Specialties: Family Practice
- Gender: Male
- Enrollment ID #: C3982
- Plans Accepted: Alliance Select, Blue Access, Blue Advantage, Blue Choice, Blue Rewards POS-Tier 2, Classic Blue, Hawk-I Blue Access, Wellmark Blue HMO, Wellmark Blue POS, Wellmark Blue PPO
- Accepting New Patients: No