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: ☐ Single ☐ Married ☐ Common Law/Domestic Partner	☐ Male ☐ Female	Date of Birth:	SSN:
Address:	City:	State:	Zip:
Phone Number:	Email Address:		Date of Hire:

Qualifying Event

☐ Marriage/Qualified Domestic Partner	☐ Divorce/Legal Separation	☐ Change in Spouse/Partner/Dependent Child Employment	☐ Other:
☐ Birth/Adoption	☐ Death	☐ Dependent Child reaches maximum age	☐ Annual Open Enrollment

Currently enrolled in:	☐ PPO Premier (74007-0001)	☐ PPO Choice (74007-1000)	☐ HMO Essential [1] (92400-0000)
Change to (during open enrollment only):	☐ PPO Premier (74007-0001)	☐ PPO Choice (74007-1000)	☐ 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	☐ Employee Only	☐ Employee Only	☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee+Spouse/Partner	☐ Employee+Spouse/Partner	☐ Employee+1	☐ Employee+1	☐ Family	☐ Family
☐ Employee+Child(ren)	☐ Employee+Child(ren)	☐ Family	☐ Family		☐ No Change
☐ Family	☐ 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					☐M ☐F	☐Medical ☐Dental ☐Vision
Eligible Child					☐M ☐F	☐Medical ☐Dental ☐Vision
Eligible Child					☐M ☐F	☐Medical ☐Dental ☐Vision
Eligible Child					☐M ☐F	☐Medical ☐Dental ☐Vision
Eligible Child					☐M ☐F	☐Medical ☐Dental ☐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:

☐ Full-Time Board Approved (Kirkwood) ☐ Full-Time/Non-Board Approved(Kirkwood) ☐ Retiree (PPO-P 74007-0008)

☐ Full-Time Board Approved (Hotel) ☐ Full-Time/Non-Board Approved (Hotel) ☐ Retiree (PPO-C 74007-1008) ☐ MIIP

☐ Retiree (HMO-E 92400-0008) ☐ 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 by 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:

- 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
- 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:

- Marriage
- Adoption or placement for adoption of a child
- Birth of a child (60 day period to enroll)

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

- Title XIX/Hawk-I program (or any other state CHIP program) (60 day period to enroll)
- Medicaid (60 day period to enroll)

Section 125 Qualifying Events: In addition to the above HIPPA 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:

- Termination of employment
- Commencement or return from a leave of absence
- Commencement of employment
- Change in employment class resulting in eligibility for/loss of eligibility for group coverage

Changes in Cost or Coverage

- Significant cost changes in employee contributions for a benefit option
- Change in coverage under another employer plan (spouse/partner's plan enrollment period does not coincide with employee's enrollment period)
- Enrollment into a Qualified Health Plan through the Healthcare Marketplace/Exchange

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:	☐ Medical	☐ Dental	☐ Vision

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: