HOOSIER HEARTLAND SCHOOL TRUST
EMPLOYEE CHANGE/TERMINATION FORM

Monroe Gregg School District

The HHST is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for this multiple employer welfare arrangement.

EMPLOYEE INFORMATION

First MI Last	Social Security #	Date of Birth - mm/dd/yyyy	Home Phone ( ) Work Phone ( ) Email

Address:

_____ _____ _____ _____

Street (include PO if applicable) City State Zip

PLAN AND STATUS SELECTION: ***The Plan you select for September through the Trust Plan will determine your deductible and out-of-pocket limit for the remainder of the calendar year. Anything you have accumulated will roll-over and help to satisfy the remainder of this year's limits. Your deductible and out-of-pocket maximum will reset January 1.***

Circle One	Active 0037	Retiree 0041	COBRA 0045	Active 0038	Retiree 0042	COBRA 0046	Active 0039	Retiree 0043	COBRA 0047	Active 0040	Retiree 0044	COBRA 0048
Employee	☐ PPO 1			☐ PPO 2			☐ HDHP 1			☐ HDHP 2		
EE/Child(ren)	☐ PPO 1			☐ PPO 2			☐ HDHP 1			☐ HDHP 2		
EE/Spouse	☐ PPO 1			☐ PPO 2			☐ HDHP 1			☐ HDHP 2		
Family	☐ PPO 1			☐ PPO 2			☐ HDHP 1			☐ HDHP 2		

REQUEST FOR CHANGE: Indicate below the information you wish to change

Please Check One or More as Reason for Change:

☐ Request to Terminate Member Coverage - Effective Date of Termination: _____

☐ Request for Early Retiree Status - Effective Date of Retirement: _____

☐ Name Change FROM:_____ TO:_____ Effective Date: _____

☐ Address Change FROM: _____

TO: _____ Effective Date: _____

☐ Change in Marital Status Marriage Date:_____ Date of Divorce or Legal Separation:_____

Dependent Status Change:

☐ I wish to drop the dependent(s) listed below from my health coverage effective: _____
(Re-enrollment in medical coverage for a dependent(s) are not permitted unless coverage is lost due to a HIPAA qualifying event)

☐ I wish to add the dependent(s) listed below to my health coverage effective: _____

Does dependent being added have previous coverage? ☐No ☐Yes

If Yes, Name and Address of Previous Coverage:_____ Effective Date:_____ Termination Date:_____

Does dependent(s) have other coverage (including Medicare) ☐ No ☐Yes

If Yes, Name and Address of Other Coverage:_____ Effective Date:_____ Policy#_____

First Name	MI	Last Name	Social Security #	Date of Birth mm/dd/yyyy	Gender	Spouse / Relationship to EE:
					☐ Male ☐ Female	Spouse
					☐ Male ☐ Female	☐ Child ☐ Other
					☐ Male ☐ Female	☐ Child ☐ Other
					☐ Male ☐ Female	☐ Child ☐ Other

All required paperwork must accompany this form in order to process the change. If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. All enrollments must be submitted within 31 days of the qualifying event. The information completed above supersedes all prior requests.

Employee Signature_____ **Date** _____

OFFICE USE ONLY

Hire/Rehire Date : **Change Effective Date:** **Termination Code:** ***(check appropriate box)***

☐ Death of Subscriber ☐ Subscriber's Request ☐ Divorce/Legal Separation ☐ Retired
☐ Left Employment ☐ Marriage ☐ Over Age Dependent

Signature of School Benefit Coordinator:_____ **Date:**_____

HHST OFFICE USE ONLY **Spouse: Marriage Certificate** _____ **Child: Birth Certificate** _____ **UHC** _____
Current Tax / Bill Doc _____ **Court Order/Adoption Decree** _____ **2019**