

Special Enrollment Notice
Under HIPAA (Health Insurance Portability and Accountability Act of 1996)

Employee Name _____ SSN _____ Date _____

Special rules may apply to you and/or your spouse and/or your child/ren in the **event of marriage, birth, adoption or the placement for adoption or the loss of other coverage.**

Under these rules, a group health plan must provide a special enrollment period for these individuals should they request enrollment within **30 days** after a special enrollment event has occurred.

Special Enrollment periods may apply to you and/or your spouse and/or your child/ren if you have a new dependent as a result of marriage, birth, adoption or the placement for adoption.

Under these rules, a group health plan is required to provide a special enrollment period for these individuals should they request enrollment within **30 days** after a special enrollment event has occurred.

I am requesting a Special Enrollment (circle all that apply) for: **myself spouse dependents**

Because of: _____

My Marriage (Date) _____ **Birth of child** (Date) _____

Adoption or Placement for Adoption of/a Child/ren on (Date) _____

Signed: _____ Date: _____

LOSS OF OTHER COVERAGE When you declined enrollment for yourself or your dependents (including your spouse) **and stated in writing that you and/or your dependents had coverage** under another group health plan or health insurance coverage was the reason for declining to enroll, then special rules may apply to you and/or your spouse and/or your child/ren **in the event you and/or your dependents have lost this other coverage due to the loss of eligibility.** If you and/or your dependents have **COBRA** continuation coverage, you will **not be eligible** for a Special Enrollment until **COBRA** continuation coverage has been exhausted or terminated as a result of loss of eligibility.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause **(such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).**

Under these rules, a group health plan is required to provide a special enrollment period for your and/or your dependents should you/they request enrollment within **30 days** after the loss of other coverage has occurred.

Circle all that Apply

I am requesting a Special Enrollment (circle all that apply) for: **myself spouse dependents**

Due to the Loss of Other Coverage (date of loss) _____ from:

My spouse's group plan **COBRA** Continuation Coverage **another insurance plan**

other: (please state reasons loss occurred)

Policyholder's Name

Social Security Number

ID Number (if different from SSN)

Address

Phone Number

Signed:

Date: