
Health Care Plan – Special Enrollment Form

Special Enrollment Request

Carefully review the following information, complete the [Required Information](#) section, and send as directed.

Our records show that you are requesting enrollment for you and/or your dependents due to a loss of other coverage. The purpose of this form is to advise you of your special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and facilitate the collection of necessary information relating to your prior coverage.

I. Summary of Special Enrollment Provision

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage for such individuals, and that coverage terminated due to certain qualifying reasons (i.e., exhaustion of COBRA or state law continuation rights; loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours; or because employer contributions for the other non-COBRA coverage cease) you may enroll yourself or your dependents (whose other coverage terminates for a qualifying reason) in this plan, provided that you request enrollment within 31 days after your other coverage ends, and that you meet certain other important conditions described in the plan SPD (Summary Plan Description).

II. Required Information

Instructions:

Please complete all of the following information and return the form with a HIPAA Certificate for the terminated coverage to Jennifer Stewart, Benefits Manager.

The information you submit will be reviewed to determine whether you qualify for a special enrollment in the Plan. We will notify you of our determination.

Employee Name (Print): _____ **Date:** ____/____/____

Name of the individual(s) to be enrolled (Print): _____

Dates other coverage was in force: **Effective Date:** ____/____/____ **Termination Date:** ____/____/____

Reason other coverage terminated: _____

Is a HIPAA Certificate relating to the terminated coverage attached? (check one) Yes No

If not, please provide:

Name of prior plan (Print): _____

Contact name (Print): _____ **Phone Number:** (____) ____ - _____

If you have any questions about this form or your eligibility for coverage under our Plan, please contact me at Drury University, 900 N. Benton Avenue, Springfield, MO 65802, (417) 873-6858, jenniferstewart@drury.edu, and I will assist you.

Jennifer Stewart, Benefits Manager, on behalf of Drury University, the plan administrator