MONTANA
WAIVER OF COVERAGE

PacificSource HEALTH PLANS

Montana Food Distributors Association

Complete this form to waive coverage. If enrolling in coverage, complete an enrollment application instead.

Group Policy No., if known	Employee Classification	Plan Design

EMPLOYEE INFORMATION

Employer/Group Name	Effective Date of Waiver month_____ day_____ year_____
Employee Name	Employee Hire Date month_____ day_____ year_____
Address City State Zip	Social Security Number

Date of Birth month_____ day_____ year_____	Gender ☐Male ☐Female	Marital Status ☐Married ☐Single ☐Domestic Partner	Number of Hours Worked per Week

EMPLOYEE AND FAMILY MEMBERS WAIVING OR DECLINING COVERAGE

Person(s) Waiving Coverage (First, MI, Last)	*Date of Birth (mm/dd/year)*	*Gender*	*Waiving*
Employee		☐Male ☐Female	☐Medical ☐Dental
Spouse or Domestic Partner		☐Male ☐Female	☐Medical ☐Dental
Dependent Child		☐Male ☐Female	☐Medical ☐Dental
Dependent Child		☐Male ☐Female	☐Medical ☐Dental
Dependent Child		☐Male ☐Female	☐Medical ☐Dental
Dependent Child		☐Male ☐Female	☐Medical ☐Dental

WAIVER INFORMATION

Medical Waiver–Reason medical coverage is being declined (required if waiving medical coverage)

☐I have qualifying Medical coverage through (list carrier name and check coverage type):

*Name of Insurance Carrier:*_____

Through: ☐My other employer ☐My spouse's employer ☐My parent's employer ☐Medicare ☐Medicaid ☐Tricare ☐Indian Health Service

☐I have other Medical coverage through Individual Policy – Are you an American Indian or Alaskan Native ☐Yes ☐No

☐I do not have other Medical coverage and am not enrolling because (please explain):_____

Dental Waiver–Reason dental coverage is being declined (required if waiving dental coverage)

☐I have qualifying Dental coverage through (list carrier name and check coverage type):

*Name of Insurance Carrier:*_____

Through: ☐My other employer ☐My spouse's employer ☐My parent's employer ☐Medicare ☐Medicaid ☐Tricare ☐Indian Health Service

☐I have other Dental coverage through an Individual Policy – Are you an American Indian or Alaskan Native ☐Yes ☐No

☐I do not have other Dental coverage and am not enrolling because (please explain):_____

MINIMUM PARTICIPATION REQUIREMENTS

Small Group with 50 or Fewer Employees: 70% of all eligible employees not otherwise covered by other group coverage must enroll.

Large Group with 51 or More Employees: 75% of all eligible employees not otherwise covered by other group coverage must enroll.

Any Size Group on Voluntary Dental: 0% / 0% *(requires at least 20% participation and 10 enrolled employees)*

IMPORTANT – PLEASE READ AND SIGN

Statement of Declination of Coverage: I hereby decline coverage in the group plan offered by my employer as indicated above. I understand that if I decline coverage during my initial enrollment period, I must wait until my employer's next open enrollment period to enroll unless I qualify for special enrollment as outlined on the back of this form.

Employee Signature _____ Date _____

EMPLOYER SECTION

Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? ☐ No ☐ Yes

Authorized Signer Signature _____ Date _____ Please Print Name of Authorized Signer _____

Special Enrollment Periods
You and your family members may decline coverage during your initial enrollment period. If you wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under the Special Enrollment Rules below.

To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator.

- Special Enrollment Rule #1 – If you declined enrollment for yourself or your family members because of other qualifying health insurance coverage, you or your family members may enroll in the plan later if your other coverage ends involuntarily. To do so, you must request enrollment within 60 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

  Examples of other qualifying coverage ending involuntarily include:

  - Continuation was exhausted;
  - Employment terminated;
  - Other plan was discontinued;
  - Work hours were reduced below the minimum requirement;
  - Death of a spouse;
  - Divorce, or legal separation; and/or
  - Termination of employer contributions by the other employer.

- Special Enrollment Rule #2 – If you acquire new family members because of marriage, newly qualified domestic partnership, birth, placement of foster child, or placement for adoption, you may be able to enroll yourself and/or your newly acquired family members at that time. To do so, you must request enrollment within 60 days after the marriage, qualification of the domestic partnership, birth, placement of foster child, or placement for adoption. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the marriage or qualification of the domestic partnership. In the case of birth placement of foster child, or placement for adoption, coverage begins on the date of birth or placement.

- Special Enrollment Rule #3 – If you or your family members become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your family members at that time. To do so, you must request enrollment within 60 days of the date you and/or your family members become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment
If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's next designated open enrollment period.

A 'late enrollee' is an otherwise eligible employee or family member who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the initial enrollment period; or

- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by either submitting an enrollment application to your employer or through your state's Insurance Exchange during the open enrollment period. When you or your family members enroll during the open enrollment period, plan coverage becomes effective the first day of the plan year.

Dental Re-enrollment Period
An employee or dependent that did not enroll within the 31-day initial enrollment period may enroll later on the policy's anniversary date. An employee or dependent that enrolled and later discontinued coverage may re-enroll in the plan on an anniversary date of the policy following a 24-month waiting period from the date coverage was discontinued.