HEALTH PROFESSIONS OF MONTANA PLAN & TRUST

PRINT

CLEAR FORM

REQUEST FOR ENROLLMENT CHANGE

Group Name: **Date:**

☐ ADDRESS CHANGE _____ (DATE) ☐ RETIREE STATUS _____ (DATE)
☐ NAME CHANGE – Please indicate YOUR PRIOR name so we can correctly identify you:_____

Name: **MI:** **Last Name:**

Mailing Address:

City: **State:** **ZIP:**

Phone: **SSN:** **E-mail:**

☐ **ADD**

Effective Date for Add

Effective date for Add must be first of the month following event, except for birth. Addition of newborn is effective on date of birth.

Reason for Add

- ☐ Open Enrollment
- ☐ Marriage/Domestic Partner (provide documentation)
- ☐ Birth
- ☐ Adoption/Disabled Dependent/Legal Guardianship/Court Order(provide documentation)
- ☐ Loss of Other Coverage (provide reason and documentation)

☐ **DROP**

Effective Date for Drop

Effective date for Drop must be first of the month following event.

Reason for Drop

- ☐ Divorce / Legal Separation (provide documentation)
- ☐ Medicare Eligible
- ☐ Termination - Voluntary
- ☐ Termination - Involuntary
- ☐ Other Coverage
- ☐ Other (please explain)

Add/Drop Dependent Information:

IF DROPPING COVERAGE: I understand that dropping coverage may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document.

First Name	M	Last Name	SSN	Date of Birth	M/F	Spouse/Domestic Partner/Child	Medical		Dental		Vision	
							Add	**Drop**	**Add**	**Drop**	**Add**	**Drop**
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐

Secondary Coverage: ☐ **I/My dependents do not have other coverage** ☐ **I/My dependents have other coverage**

Please list other coverage:

I certify that the information on this form is true and accurate. I UNDERSTAND that providing inaccurate or incorrect information on this form may be considered health insurance fraud and may result in denial or cancellation of coverage from its beginning.

SIGNATURE OF APPLICANT **DATE**

SIGNATURE OF EMPLOYER **DATE**

EMPLOYER: This enrollment change form has been reviewed by the Employer group to confirm that the employees and/or family members who are enrolled or applying for enrollment meet all eligibility requirements of the HPMPT under the Plan Document and SPD and the Adoption Agreement between the HPMPT and the Employer Group. You may make changes 1) directly on SIMON enrollment system or 2) by sending this form by fax to 406-502-1017 or SECURE email to ksweeney@hpmpt.org.

IMPORTANT - The employer must keep this form and any verifying documentation needed on file for a minimum of four years.