

# NOTICE OF ENROLLMENT RIGHTS

Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Social Security No. \_\_\_\_\_

**Initial Enrollment**

You have completed the waiting period of \_\_\_\_\_ days and are now eligible to enroll yourself and/or your dependents in our Company's Group Health Plan.

**Special Enrollment**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent's in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 30 days after you or your dependents other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

**Plan Administrator:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

Under these rules, a plan or issuer must allow an employee a period of at least 30 days after a loss of eligibility to request enrollment (for the employee or the employee's dependent). In the case of a loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

***If you are declining enrollment, please complete a Notice of Declining Enrollment form to protect your rights of Special Enrollment.***

**Annual Open Enrollment**

Your plan may offer an Annual Open Enrollment giving you the opportunity to enroll yourself and/or your dependents if you have previously declined/waived coverage for you and/or dependents.

***Please check with your plan administrator to verify if this option is available to you and/or your dependents.***

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_