MAINE AUTOMOBILE DEALERS ASSOCIATION INSURANCE TRUST # F500
PARTICIPANT CHANGE FORM

☐ **CHANGE (Effective Date)** _____ **Division** _____

Employee Name_____ **Soc. Sec.#**_____ **Dealership**_____

1. NAME/ADDRESS CHANGE

Change Name: ☐ Employee ☐ Family Member

From_____ To _____

Change Address To:

_____
Street

_____
City State Zip

2. MEMBERSHIP CHANGE

Status Change Reasons:

A. Marriage
B. Birth
C. Divorce
D. Adoption
E. Legal Separation
F. Death
G. Laid Off
H. Unpaid Leave
I. Military
J. Term. of Spouse's Employment
K. Start of Spouse's Employment
L. From Full-time to Part-time
M. Dependent no longer meets definition
N. Medicaid
O. Termination of Employment
P. Other_____

CHANGE REASON	Effective Date of Event	ADD	DROP	MEDICAL	DENTAL	NAME (List Employee and all dependents to change or term)	SOCIAL SECURITY #	RELATION	BIRTHDATE	SEX

3. PRIOR COVERAGE INFORMATION

Have any family members ADDED on this application had health insurance coverage within the last 90 days? Yes ☐ **No** ☐ *If yes please complete the following:*

Certificate Number: Spouse's_____ **Dependent's**_____

Insurance Company_____

City_____ **State**_____ **Date Coverage Began**_____ **Date Coverage Ended**_____

4. SPECIAL ENROLLMENT

If you are declining enrollment in the Plan for yourself or your dependents (including your spouse) because you and your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

5. SIGNATURE

I am requesting coverage for myself and all dependents listed on this form, and I authorize my employer to deduct any required contributions for this coverage from my earnings. All statements and answers I have given are true and complete. I understand that if I have provided any false, incomplete, or misleading information, then my coverage under this Plan may be null and void and may result in a denial of all benefits. I understand that all benefits are subject to the terms and conditions stated in the Plan Document. I authorize all health care providers, third party payers, utilization review agencies, my employer, and state or federal agencies to exchange all demographic, medical, mental health, AIDS and HIV, and substance abuse information with Anthem Blue Cross Blue Shield of Maine or its designees necessary for claims processing, clinical studies, care management, Plan administration, or benefit administration. I understand any information will be used only after issuance of Plan coverage and will have no effect on determination of eligibility to enroll.

I give this consent for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that failure to sign this authorization may be a basis for enrollment or benefit denial. I understand that I am entitled to receive a copy of this authorization. I further understand that this authorization will remain in effect until coverage under this Plan ends or I give written notice to Anthem Blue Cross Blue Shield of Maine that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits. In signing this application I certify that: I have read and understand all the information on this form.

_____ _____ _____ _____
Employee Signature Date Dealership Signature Date

_____ _____
Dependent Signature(s) 18 and over Date

Note: Please return completed form to:

Maine Automobile Dealers Association Insurance Trust
Attn: Membership Administration
180 Civic Center Drive
PO Box 2667
Augusta, ME 04338-2667 FAX # 207-623-2318