Drake
DRAKE UNIVERSITY

First Administrators, Inc.

Special Enrollment

Applicability

Special Enrollment applies to you and/or your Dependent(s) if you/they are eligible for coverage under your employer's group health insurance policy, and qualify under one of the Special Enrollment Conditions described below. If you feel you qualify under one of these conditions, please submit the form on the reverse side to your employer within the time period designated below for that special enrollment condition. We will review the information provided and notify your employer regarding the status of your coverage, including the effective date of coverage for approved requests.

Special Enrollment Conditions

If you previously declined enrollment for yourself or your Dependent(s), you and your Dependent(s) may qualify for **Special Enrollment** under the following five conditions:

Condition 1: Loss of Other Coverage

- You and/or your Dependent(s) were covered under another group health policy, or had other public or private health insurance coverage at the time of your initial eligibility, and declined enrollment solely due to that coverage; and
- the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment, or reduction in work hours), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation).

A request for enrollment under this condition must be made within 31 days after the other coverage terminates.

NOTE: "Loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the health coverage). "Employer contributions" include contributions by any current or former employer (of the individual or another person) contributing to the individual's coverage.

Condition 2: Newly Acquired Dependents

You are already enrolled under your employer's health insurance policy (or are eligible to be enrolled but have not enrolled during a previous enrollment period), and a person becomes your Dependent through marriage, birth, adoption, or placement for adoption.

A request for enrollment for you (if not already enrolled) and your Dependent under this condition must be made within 31 days after the latter of:

- the date of the marriage, birth, adoption or placement for adoption; or
- the date Dependent medical expense coverage is available to you under the policy, provided you are enrolled (or eligible to be enrolled, but have not enrolled during a previous enrollment period).

Condition3: Court Ordered Coverage

You are enrolled under your employer's health insurance policy, and a court or administrative order is issued that required you t o provide health coverage for a spouse or Dependent Child(rent). A request for enrollment under this condition must be made within 31 days after the court/administrative order is issued.

Condition 4: Election of Different Plan During Open Enrollment Period

Your employer offers multiple health plans, and a request for enrollment under this policy is made during the open enrollment period established for plan election.

Condition 5: Change in Employee's Status

You change employee status, becoming eligible (along with your Dependents) for coverage under the group policy. A request for enrollment under this condition must be made within 63 days of your change in employee status.

A. To Be Completed by the Employee

I qualify for the following Special Enrollment Condition: (Please mark one box) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Condition 1: Loss of Other Coverage (Please complete the following if you have lost other health coverage. If available, please also attach any certificate(s) of creditable coverage you received from the prior plan or carrier.)

Name of carrier (if applicable)	Name of employer/sponsor (if applicable)	Account number
Date coverage ended	Reason coverage ended	

Condition 2: Newly Acquired Dependents (Please complete the following if you have acquired a new Dependent as described on the reverse side of this form.)

Event ❑ Marriage ❑ Birth of Child ❑ Adoption or placement for adoption

Date of the event

Condition 3: Court Ordered Coverage (Please complete the following and attach a copy of the court order.)

Name(s) of Dependent(s) for whom coverage is mandated	Date court order was issued

Condition 4: Election of Different Plan During Open Enrollment Period (Please complete the following.)

Individuals Covered	Name of other plan
Open enrollment period (beginning and ending date)	Termination date of coverage under the other plan

Condition 5: Change in Employee Status (Please complete the following information.)

What was the nature of the employee status change:	Effective date of status change

Member/Dependent Information (Complete the following Member and Dependent information for Conditions 1, 2, 3, 4 & 5)

Are you currently covered under the group policy of your employer? ❑ Yes ❑ No

I elect coverage for (check all appropriate boxes) ❑ Myself ❑ Spouse ❑ Child(ren)

Spouse	Date of birth	Social security number	Child is a Full-time student	Child is a Foster Child	Child is Handicapped
Child(ren)					

I represent that all statements/answers made above are true, complete, and correct. They will be part of my application for coverage. I agree that the coverage of anyone for whom such statements and answers are made will not be in force until approved by First Administrators, Inc. at its home office in Sioux City, Iowa. Coverage is then provided as specified in the group policy.

Employee's signature	Date of signature

B. To be completed by the Employer

Account number	Employer's name: Drake University

The employee whose signature appears above signed this form in my presence on the date indicated. To the best of my knowledge and belief, the statements and answers made above are true and complete.

Employer's signature	Employer's title	Date of signature