Community College System of New Hampshire
Medical Benefits Buy-Out Program
Enrollment/Change Form

INSTRUCTIONS: Please see instruction sheet before completing.

ENROLLMENT ☐ Open Enrollment - Complete Sections I, II and IV.
(Check One): ☐ Mid-Year Enrollment (effective Qualifying Event date) - Complete Sections I, II, III, and IV.

I. EMPLOYEE (PARTICIPANT) INFORMATION (Please Print)

LAST NAME:	FIRST NAME:	M.I.	SSN:
HOME ADDRESS:			
CITY:	STATE:	ZIP CODE + FOUR:	
PRIMARY PHONE:	WORK PHONE:	E-MAIL:	
CCSNH INSTITUTION:			

II. CCSNH MEDICAL BENEFITS BUY-OUT PROGRAM SECTION. If completing this section during mid-year, you must also complete Section III below.

A. To participate in the Medical Benefits Buy-Out Program you must complete this form. Return this form along with proof of non-CCSNH health insurance to the CCSNH Human Resources Department for approval and completion.

☐ **I wish to participate in the Medical Benefits Buy-Out Program**. Check only one:
☐ Employee Coverage ($2,000) ☐ Two-Person Coverage ($3,000) ☐ Family Coverage ($4,000)

Non-CCSNH group health plan provider (company name) _____

***Please note: You must attach proof of non-CCSNH health coverage (letter from health insurance provider or employer verifying coverage AND a copy of your health insurance card).**

B. To terminate your participation in the Medical Benefits Buy-Out Program, you must complete this form *and* a Health Benefits on-line enrollment process for reinstating CCSNH health benefits. Documentation verifying the "qualifying event" is required and must be submitted to the CCSNH Human Resources Department for approval and completion.

☐ **I wish to withdraw from the CCSNH Medical Benefits Buy-Out Program.**

III. MID-YEAR QUALIFYING EVENT. Newly eligible employees or current employees changing their status during mid-year must complete this section.

This is to certify that I incurred the Qualifying Event indicated below and, therefore, wish to modify my benefits as indicated. I understand that the change(s) requested must be consistent with the Qualifying Event and that I must submit this form with legal/supporting documentation of all changes to the CCSNH Human Resources Department within 31 days after the Qualifying Event to take effect.

Date of Qualifying Event: _____ Today's Date: _____
If Today's Date is more than 31 days from the Date of Qualifying Event, please note that you are not eligible for this Plan Year.

Please check one of the following:

Employment Status: Documentation must be provided by employer/agency

☐ **Beginning/termination of employment (** ☐ **self** ☐ **spouse)**
☐ **Unpaid leave of absence (** ☐ **self** ☐ **spouse)**
☐ **Return from unpaid leave of absence (** ☐ **self** ☐ **spouse)**
☐ **Change from P/T to F/T employment or vice versa (** ☐ **self** ☐ **spouse)**

Family Status Change: Legal documentation must be provided by participant

☐ **Marriage**
☐ **Birth or adoption of child**
☐ **Divorce**
☐ **Ineligibility of dependent (** ☐ **age** ☐ **marriage)**

IV. EMPLOYEE SIGNATURE

I have read the CCSNH Medical Benefits Buy-Out Program materials and instructions and I attest that I meet the qualifications to enroll or withdraw from the Program. I understand that the election to opt out of the Program is entirely voluntary and that if I elect to opt out, any dependent coverage will also be terminated and that I and my covered dependents are not eligible for COBRA continuation coverage. I further understand that I must furnish proof of enrollment in another health benefit plan from a source other than the CCSNH before my coverage will be terminated. My medical coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted, and such documentation has been approved by the CCSNH.

Signature: _____ Date: _____

V. FOR COMPLETION BY CCSNH HUMAN RESOURCES DEPARTMENT. Please review the above information and submitted documentation from employee.

Withdrawal (opt-out) Effective Date: _____ **Enrollment Effective Date:** _____

Processor: _____ **Processing Date:** _____

Date of Last Revision: 3/1/18