



Are you or your dependents not covered under the HOPE Trust Health Care Plan as provided by your employer? If so, you may be eligible to enroll soon.

OPEN ENROLLMENT PERIOD: OCTOBER

(Coverage to become effective January 1st)

Eligible employees and their dependents who are not already enrolled in the HOPE Trust Health Care Plan may enroll during the month of October with coverage effective the immediately following January 1st. Enrollees must satisfy any requirements or criteria to participate as specified by the HOPE Trust Health Care Plan. **Check with your employer's designated health benefits administrator or human resources contact person to verify your eligibility to enroll and the cost of coverage.**

Additionally, eligible employees and their dependents who *are* already enrolled in the HOPE Trust Health Care Plan may *change* their plan option selection during the month of October for a January 1st effective date (if your employer offers multiple major medical plan (or QHDHP) options).

A couple additional points:

- An employee *cannot* be covered under a different plan option (including QHDHP, if available) than his/her spouse or child(ren) who are also covered through the HOPE Trust (*all must be under the same plan option, with the exception of certain HRP participants enrolled in Medicare Parts A, B, & D or participants in the HRP plus Premiums Program*).
- An employee *cannot* change from one major medical plan option (including QHDHP, if available) to another major medical plan option during the plan year (*an election to change may only be made during the October open enrollment, effective January 1st*), unless a permitted special enrollment opportunity applies (refer to plan document or inquire with HR for more details).

All necessary enrollment forms must be completed, signed, and returned during the month of October. Even those declining the offer to enroll must sign off for your employer's records.

Thank you!

Need more coverage options? You and your family may be eligible to enroll in other more affordable coverage options through the Health Insurance Marketplace or Medicaid at www.healthcare.gov

Employer Record of Enrollment Offer

EMPLOYER SHOULD RETAIN COMPLETED FORM FOR RECORDS

ALREADY ENROLLED (NO CHANGES)

I am already enrolled along with any of my selected dependents (if applicable) in the HOPE Trust Health Care Plan and do not wish to add any additional dependents at this time or change my plan selection for the next plan year. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

ACCEPT (OR CHANGE PLAN)

I accept the opportunity to enroll myself and my selected dependents (if applicable) or to add additional dependents or to change my plan selection for the next plan year in the HOPE Trust Health Care Plan and at the prevailing cost (if any) required for participation. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.

*** (Additional Employee Enrollment Form must be completed.) ***

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

DECLINE

I DO NOT WISH TO ENROLL myself or my selected dependents in the HOPE Trust Health Care Plan at this time and understand the option to enroll at any future time will be limited to special enrollment opportunities or during open enrollments as provided under the terms of the HOPE Trust Health Care Plan.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

EMPLOYER USE ONLY -- ENROLLMENT OFFERED FOR: _____ New Hire/New Full-Time (FT) Hire Date: _____

Special Enrollment (Event: _____)

Open Enrollment (MM/YYYY): _____ / _____