RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

MERITAIN HEALTH
An Aetna Company

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION
(Employer Representative – Unsigned or Incomplete forms will be returned and may delay enrollment)

(For Employer Use Only) – Retain a copy for your records.
Confirmation No._____

Employer Name	Group Number	Date of Hire	Effective Date of Change
REQUIRED	REQUIRED	REQUIRED	REQUIRED

Certified by (Authorized Representative)	Date	Employer Telephone
REQUIRED	REQUIRED	

Employers please indicate which Health Plan options your district offers: REQUIRED

☐ Plan A ☐ Plan B ☐ Plan C ☐ HDHP ☐ Plan E1 ☐ All Plans

Enter information at www.meritain.com or

ENROLLMENT CHANGE SECTION Effective Date of Change_____/_____/_____ (indicate changes below) REQUIRED

EMPLOYEE INFORMATION – EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)

Employee Name (Last, First, MI)	Sex	Date of Birth	Social Security Number
REQUIRED	☐ M ☐ F REQUIRED	REQUIRED	REQUIRED

Will Employee be Medicare Eligible at age 65? ☐ Yes ☐ No HELPFUL BUT NOT REQUIRED

	From:	To:
☐ Employee Name	REQUIRED ONLY IF CHANGING	REQUIRED ONLY IF CHANGING.
☐ Employee Address	REQUIRED ONLY IF CHANGING.	REQUIRED ONLY IF CHANGING.
☐ Employee Phone	REQUIRED ONLY IF CHANGING.	REQUIRED ONLY IF CHANGING.
☐ Employee Email	REQUIRED ONLY IF CHANGING.	REQUIRED ONLY IF CHANGING.
☐ Employee Certification	☐ Yes ☐ No HELPFUL BUT NOT REQUIRED	☐ Yes ☐ No HELPFUL BUT NOT REQUIRED
☐ Marital Status	☐ Single ☐ Married ☐ Civil Union ☐ Divorced REQUIRED ONLY IF CHANGING.	☐ Single ☐ Married ☐ Civil Union Termination ☐ Divorced REQUIRED ONLY IF CHANGING.

☐ Termination If any or all coverage being terminated this is required with a reason.

Choose Reason

☐ Active ☐ Reduction In Hours ☐ Leave of Absence
☐ Lay Off ☐ Medicare Entitlement ☐ Terminate Employment
☐ Death ☐ Marriage ☐ Divorce
☐ Retired ☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Other Must have a reason !! Effects COBRA offer.

You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.

☐ Dependent Status

(When adding or terminating a dependent you must complete Dependent Section on the reverse side.)

If adding or terminating any dependent this must be marked.

☐ Add Dependent(s)

Reason for Addition: Must be marked when adding dependent.

☐ Newborn ☐ Adoption
☐ Marriage ☐ Divorce
☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Newly Eligible Full-time Student

Must have a reason when adding dependent

☐ Other _____

☐ Terminate Dependent(s)

Reason for Termination: Must be marked when terminating dependent.

☐ Ineligible Child
☐ Marriage ☐ Divorce
☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Death

Must have a reason when terminating dependent

☐ Other _____

EMPLOYEES: You must check one box in each column below: REQUIRED – ONE OF THESE BOXES MUCH BE MARKED FOR EACH PRODUCT.

Medical

Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event. You may only change to a higher level of benefits with a 12 month notice to your employer.
EMPLOYERS: ATTACH A COPY OF 12 MONTH NOTICE TO CHANGE FORM. Plan must be marked when changing a plan.

TO: ☐ Plan A ☐ Plan B ☐ Plan E1 ☐ Plan C ☐ HDHP

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child or Children
☐ Family
☐ Terminate Medical
☐ No Change Medical One of these boxes must be marked.

Voluntary Teladoc

☐ Employee Only
☐ Terminate
☐ No Change

One of these boxes must must be marked.

Voluntary Dental

Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.

TO: ☐ High ☐ Low

Plan must be marked when changing a plan.

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Dental
☐ No Change Dental

One of these boxes must be marked.

Voluntary Vision

Changes to voluntary vision plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.

TO:

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Vision
☐ No Change Vision

One of these boxes must be marked.

Basic Life – All life insurance terminates upon employment termination or retirement.

☐ Add Basic Life (Only available when employee is newly eligible.)
☐ Term Basic Life
☐ No Change

One of these boxes must be marked.

Optional Life – Changes in Optional Life coverage must be submitted using the Dearborn National Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org.

EMPLOYEES: Check all boxes that apply:

☐ Add Optional Employee (Evidence of Insurability REQUIRED)
☐ Add Optional Spouse (Evidence of Insurability REQUIRED)
☐ Add Optional Dependent(Evidence of Insurability REQUIRED)
☐ Terminate Optional Employee
☐ Terminate Optional Spouse
☐ Terminate Optional Dependent

☐ No Change Optional Life One of these boxes must be marked.

DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number	You must check one box in each line below for each dependent listed. One box in each row must be marked.
1. REQUIRED WHEN ADDING OR TERMINATING A DEPENDENT	REQUIRED	REQUIRED	REQUIRED	REQUIRED	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
2.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
3.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
4.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline

BASIC LIFE – CHANGE Beneficiary Information NOT REQUIRED. IF WE HAVE THE INFORMATION ON THIS FORM WILL ENTER IT BUT WILL NOT REQUIRE IT.

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.

Street Address	City	State	Zip

Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.

Street Address	City	State	Zip

OPTIONAL LIFE – CHANGE Beneficiary Information NOT REQUIRED. IF WE HAVE THE INFORMATION ON THIS FORM WILL ENTER IT BUT WILL NOT REQUIRE IT.

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.

Street Address	City	State	Zip

Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's Social Security Number.

Street Address	City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

OTHER INSURANCE COVERAGE NOT REQUIRED. IF WE HAVE THE INFORMATION ON THIS FORM WILL ENTER IT BUT WILL NOT REQUIRE IT.

Are you or any of your dependents covered by another group, medical, vision, or dental plan? ☐ Yes ☐ No

If yes, type(s) of coverage: ☐ Medical ☐ Vision ☐ Dental

Name of individual with other coverage:

Name of insurance carrier or TPA:_____ Group No._____

Name of employer providing coverage:

Address:_____

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No

Phone:_____ Effective Date of other coverage:_____

Effective Date_____

ADDITIONAL CHANGES – Please add any comments concerning your changes.

IF YOU ARE UNSURE OF HOW TO COMMUNICATE A CHANGE THROUGH THE FIELDS ON THIS FORM YOU MAY COMMUNICATE IT IN THIS SECTION.

Please read, sign, and date the following Authorization & Acknowledgement

- I have read and understand the information provided in the summary of benefits and other enrollment materials.
- On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law.
- Are you declining any coverage due to coverage in another plan? ☐ Yes ☐ No
  If yes, is the other coverage COBRA? ☐ Yes ☐ No ☐ Other (Please Explain)_____

To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.

Employee's Signature REQUIRED	Date: REQUIRED

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE