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|  | **Egyptian Area Schools Employee Benefit Trust** |
| **CHANGE ENROLLMENT FORM** |

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| EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION**RETURN THIS COMPLETED FORM TO YOUR EMPLOYER**(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     /     /      |
| Certified by (Authorized Representative)      | Date      /     /      | Employer Telephone      |
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| Employers please indicate which Health Plan options your district offers: |
| [ ]  Plan A | [ ]  Plan B | [ ]  Plan C | [ ]  HDHP |  [ ]  Plan E1 [ ]  All Plans |

 | **Enter information at** [**www.meritain.com**](http://www.meritain.com) **or** |
| **ENROLLMENT CHANGE SECTION Effective Date of Change**      **/**     **/**      **(indicate changes below)****EMPLOYEE INFORMATION – EMPLOYEE MUST COMPLETE THIS SECTION** (Incomplete forms will be returned and may delay enrollment) |
| Employee Name Last First MI                    | Sex[ ]  M [ ]  F | Date of Birth     /     /      | Social Security Number       |
| Will Employee be Medicare Eligible at age 65? [ ]  Yes [ ]  No |
| [ ]  **Employee Name** | From: |      /     /      | To: |      /     /      |
| [ ]  **Employee Address** | From: |      /     /      | To: |      /     /      |
| [ ]  **Employee Phone** | From: |      /     /       | To: |      /     /      |
|      /     /      |      /     /      |
| [ ]  **Employee Email** | From: |      /     /      | To: |      /     /      |
| [ ]  **Employee Certification** | From: | [ ]  Yes [ ]  No | To: | [ ]  Yes [ ]  No |
| [ ]  **Marital Status** | From: | [ ]  Single [ ]  Married [ ]  Civil Union [ ]  Divorced | To: | [ ]  Single [ ]  Married [ ]  Civil Union Termination [ ]  Divorced |
| [ ]  **Termination**Choose Reason | [ ]  **Dependent Status**(When adding or terminating a dependent you must complete Dependent Section on the reverse side.) |
|  | [ ]  Active | [ ]  Reduction In Hours | [ ]  Leave of Absence | [ ]  **Add Dependent(s)**Reason for Addition: | [ ]  **Terminate Dependent(s)**Reason for Termination: |
|  | [ ]  Lay Off | [ ]  Medicare Entitlement | [ ]  Terminate Employment |  | [ ]  Newborn | [ ]  Adoption |  | [ ]  Ineligible Child |
| [ ]  Death | [ ]  Marriage | [ ]  Divorce |  | [ ]  Marriage | [ ]  Divorce |  | [ ]  Marriage | [ ]  Divorce |
| [ ]  Retired | [ ]  Civil Union | [ ]  Civil Union Termination |  | [ ]  Civil Union | [ ]  Civil Union Termination |  | [ ]  Civil Union | [ ]  Civil Union Termination |
|  | [ ]  Open Enrollment |  |  |  | [ ]  Open Enrollment |  | [ ]  Open Enrollment |
|  | [ ]  Other |  |  |  | [ ]  Newly Eligible Dependent  |  | [ ]  Death |
| You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law. |  |  |  |  |
|  | [ ]  Other |  |  | [ ]  Other  |  |
|  |  |  |
| **EMPLOYEES: You must check one box in each column below:**  |
| **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.****TO:** [ ]  **Plan A** [ ]  **Plan B**[ ]  **Plan E1**[ ]  **Plan C** [ ]  **HDHP** | **Voluntary****Teladoc**      | **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** | **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 Only | [ ]  Employee Only | [ ]  Employee Only |
| [ ]  Employee + Spouse | [ ]  Terminate | [ ]  Employee + 1 Dependent | [ ]  Employee + 1 Dependent |
| [ ]  Employee + Child or Children | [ ]  No Change | [ ]  Employee + 2 or more Dependents | [ ]  Employee + 2 or more Dependents |
| [ ]  Family |  | [ ]  Terminate Dental | [ ]  Terminate Vision |
| [ ]  Terminate Medical |  | [ ]  No Change Dental | [ ]  No Change Vision |
| [ ]  No Change Medical |  |  |  |
| **Basic Life – All life insurance terminates upon employment termination or retirement.** | **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 Basic Life (Only available when employee is newly eligible.) | [ ]  Add Optional Employee (Evidence of Insurability REQUIRED) | [ ]  Terminate Optional Employee |
| [ ]  Term Basic Life | [ ]  Add Optional Spouse (Evidence of Insurability REQUIRED) | [ ]  Terminate Optional Spouse |
| [ ]  No Change | [ ]  Add Optional Dependent( Evidence of Insurability REQUIRED) | [ ]  Terminate Optional Dependent |
|  | [ ]  No Change Optional Life |

(9-05) EGT-CHGENR REVISED 3/15 EMPLOYER RETAIN ORIGINAL FOR YOUR FILE

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| **DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.** |
| List Full Name of YourEligible Dependents | Relation To Employee1-Spouse2-Child3-Stepchild4-Other | Sex M or F | Date ofBirth | DependentSocial Security Number | You must check one box in each line below for each dependent listed. |
| 1.
 |        | [ ]  M [ ]  F |      /     /      |       | **Medical** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Dental** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Vision** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| 1.
 |       | [ ]  M [ ]  F |      /     /      |       | **Medical** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Dental** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Vision** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| 1.
 |       | [ ]  M [ ]  F |      /     /      |       | **Medical** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Dental** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Vision** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| 1.
 |       | [ ]  M [ ]  F |      /     /      |       | **Medical** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Dental** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **Vision** | [ ]  Add [ ]  Term [ ]  No Change [ ]  Decline |
| **BASIC LIFE – CHANGE Beneficiary Information** |
| 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** |
| 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 |
| 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 employer providing coverage:     Is other coverage Medicare or Medicaid? [ ]  Yes [ ]  No Effective Date      /     /      | Name of insurancecarrier or TPA:       Group No.      Address:      Phone:       Effective Date of other coverage:      /     /      |
| ADDITIONAL CHANGES – Please add any comments concerning your changes. |
|       |
|       |
|       |
|       |
| 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 | Date:      |
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