

# Special and Late Applicant Enrollment Form for Health Care Coverage

## Group Plans

This application is used only for circumstances where health care coverage is being requested for an individual after an employee's or dependent's initial eligibility period has passed. If the employee is enrolling in Group Plans for the first time, a Group Plans Enrollment Form **must** accompany this form for enrollment. This form is used for two classifications of individuals:

### Special enrollees

If an individual meets one of the following requirements, this person is a Special Enrollee:

- Loss of eligibility for other health care coverage, application for enrollment must be made within 31 days of the event.
- Acquisition of a dependent through marriage, birth, adoption, or placement for adoption, application for enrollment must be made within 60 days of the event (application for HMO coverage must be made within 31).

A Special Enrollee is subject to a 12-month pre-existing condition limitation period, less any creditable coverage.

**If approved, the medical coverage will become effective the day of the qualifying event.**

### Late enrollees

If an individual requests coverage after his initial eligibility period, he is considered a Late Enrollee and will be subject to a 12-month pre-existing condition limitation period, less any creditable coverage.

**If approved, medical coverage will become effective January 1, following submission of the application.**

### GENERAL INFORMATION

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_

Employee name: First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Employee address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Home telephone: (\_\_\_\_\_) \_\_\_\_\_

**Coverage is being requested for (check all that apply):**

- Self     Spouse     Dependent children

**From the choices below, please indicate the reason coverage is being requested for yourself and/or your dependents:**

- Loss of other health care coverage (indicate specific reason)    Date of event: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Company out of business     Layoff     Retirement     End of COBRA eligibility  
 Death     Divorce     Termination of employment     Other: \_\_\_\_\_
- Dependent addition (indicate specific addition)    Date of event: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Marriage     Birth     Adoption     Placement for adoption
- Late enrollment

**Return to:** GuideStone Financial Resources, SBC  
Insurance Operations — Group Plans  
2401 Cedar Springs Road  
Dallas, TX 75201-1498

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Employee name: \_\_\_\_\_ Social Security number: \_\_\_\_\_

**COVERAGE REQUESTED (CHECK ONE)**

Check one

- Health Choice 3000
- Health Choice 2000
- Health Choice 1000
- Health Choice 500
- Health Today
- Health Legacy 200
- Health Saver 2600
- HMO  \_\_\_\_\_ (requires separate HMO enrollment form)
- Senior plans  Senior Plus Plan  Senior Plan

**IF YOUR DEPENDENT(S) ARE TO BE COVERED, PROVIDE THE FOLLOWING INFORMATION**

Last name	First name	MI	Social Security number	Date of birth	Relationship	Sex M/F

Applicable to your spouse and any children to age 25 and not married who are dependent on you for support and maintenance.

**COMPLETE SIGNATURE INFORMATION BELOW**

**Attach a Certificate of Creditable Coverage from prior health care plan, if applicable.**

I hereby request my employer to arrange for the issuance of the benefits to which I am now entitled, or to which I may become entitled under the terms of the group policy or policies issued to and/or administered by GuideStone and I authorize my employer to make the proper deductions, if any, from my earnings as my contribution toward the cost of this insurance.

Employee signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer authorized representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR GUIDESTONE USE ONLY**

Coverage effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Letter \_\_\_\_\_ PCL \_\_\_\_\_

Approved by: \_\_\_\_\_ Date approved: \_\_\_\_/\_\_\_\_/\_\_\_\_