

# Senior Plans Enrollment Form

## Group Plans

### EMPLOYER INFORMATION

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ Employer Tax ID number: \_\_\_\_\_

As the employer we agree to maintain eligibility for the Senior or Senior Plus plans by contributing at least 50% of the plan cost for each employee or retiree who joins the Senior or Senior Plus plan after 1/1/09.

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

### EMPLOYEE INFORMATION

Employee first name: \_\_\_\_\_ MI: \_\_\_\_ Last name: \_\_\_\_\_

Employee address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Home telephone number: (\_\_\_\_\_) \_\_\_\_\_

Medicare Claim number (from your Medicare card): \_\_\_\_\_ Employee requested effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**Please select a Plan:**  Senior Plan  Senior Plus Plan  Care Basic Plan  Care Plus Plan

Employee and/or dependents who are not Medicare eligible will remain on the current PPO plan.

**Please provide the information below for your dependents who are Medicare eligible.**

	Dependent 1	Dependent 2	Dependent 3	Dependent 4
<b>Name of dependent</b>				
<b>Birth date</b>	____/____/____	____/____/____	____/____/____	____/____/____
<b>Social Security number</b>				
<b>Relationship</b>				
<b>Medicare Primary?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If "yes": Medicare Claim number</b>				
<b>Disabled?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Requested effective date</b>	____/____/____	____/____/____	____/____/____	____/____/____

**Important:** This form must be received and processed by GuideStone no later than the 10th of the month prior to your desired plan effective date.

#### GUIDESTONE USE ONLY

Processed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

