Employee Annual Change Request — Medical Only

Group Plans

Note: Complete and return this form to your employer to change your coverage option(s) to the plans listed below. Your employer will need to return this form to GuideStone. The coverage available for your selection is contingent upon your employer's enrollment and participation in the plan.

EMPLOYEE INFORMATION

Employee first name: ______________________ MI: _____ Last name: ________________________________ Effective date: ____________

Employee address: __________________________________ City: ___________________________ State: ________ ZIP Code: ___________

Social Security number: ____ E-mail: ____

Telephone number: ______________________ Classification: _____________________________________ (i.e. ministerial, administrative)

Please provide dependent information on the reverse side, if applicable.

EMPLOYER INFORMATION

Employer name: ____

Employer address: __________________________________ City: ___________________________ State: ________ ZIP Code: ___________

Employer number: ____ E-mail: ____

MEDICAL PLAN OPTIONS

	Check one
Health Choice 5000	☐
Health Choice 3000	☐
Health Choice 2000	☐
Health Choice 1000	☐
Health Choice 500	☐
Health Today	☐
Health Legacy 200	☐
Health Saver 2600	☐
Health Saver 2800	☐
Health Saver 3000	☐

Coverage option — Please check		
For myself	☐ Yes	☐ No
For spouse	☐ Yes	☐ No
For eligible children	☐ Yes	☐ No

AUTHORIZED SIGNATURES

Employee signature: ____ Date: ______/______/______

Employer authorized representative signature: ____ Date: ______/______/______

GUIDESTONE USE ONLY

Processed by: ____________________________________ Date: ______/______/______ PCL: ____________________ Letter: ___________

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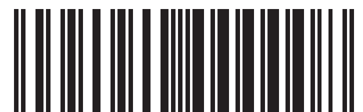
GuideStone® Insurance Plans



Employee name: ____________________ Social Security number: ____________________

LIST ALL DEPENDENTS TO BE COVERED FOR 2010

Note: Children under age 25 are eligible for coverage if they are unmarried and dependent on you for support and maintenance. "Other" dependents include stepchildren, grandchildren and foster children.

Late enrollees
If an employee or dependent requests coverage after the initial eligibility period, the individual is considered a late enrollee and will be subject to a 12-month pre-existing condition limitation period, less any creditable coverage. **Attach a certificate of creditable coverage from your prior health care plan, if applicable.**

Applicant first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: Applicant

Spouse first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: Spouse

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Dependent first name: ____________________ MI: ________ Last Name: ____________________

Social Security number: ____________________ Birth date: _____/_____/_____ ☐ Medical

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ____________________

Make copies of this page and complete if more than five dependent children will be covered.