

Employee Annual Change Request

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: January 1, 2012

Employee address: _____ City: _____ State: _____ ZIP Code: _____

Social Security number (last four digits): _____ Email: _____

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: _____ Email: _____

MEDICAL PLAN OPTIONS

Coverage option — Please check

For myself Yes No

For spouse Yes No

For eligible children Yes No

Check one

Health Legacy 200

Health Today

Health Choice 500

Health Choice 1000

Health Choice 2000

Health Choice 3000*

Health Choice 3000 80/20*

Health Choice 5000*

Health Choice 5000 80/20*

Health Saver 2600

Health Saver 2800

Health Saver 3000

Health Select 200

Health Select 500

Health Select 1000

Health Select 2000

Health Select 3000*

Health Select 5000*

*These plans do not constitute "creditable coverage" for Massachusetts residents.

DENTAL PLAN OPTIONS

Coverage option — Please check

For myself Yes No

For spouse Yes No

For eligible children Yes No

Check one

Premier Dental Care Plan

Choice Dental Care Plan

Guided Dental HMO Plan

AUTHORIZED SIGNATURES

Employee signature: _____ Date: ____/____/____

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

GUIDESTONE USE ONLY

Processed by: _____ Date: ____/____/____ PCL: _____ Letter: _____

Continued on other side



Employee name: _____ Social Security number (Last four digits): _____

LIST ALL DEPENDENTS TO BE COVERED FOR 2012

Note: Your spouse and children up to age 26 are eligible for coverage.

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. This rule does not apply to covered participants under age 19. **Attach a certificate of creditable coverage from your prior health care plan, if applicable.**

Applicant first name: _____ MI: _____ Last Name: _____

Social Security number (last four digits): _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Applicant

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Spouse first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Spouse

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Dependent first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Child Other: _____

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Dependent first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Child Other: _____

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Dependent first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Child Other: _____

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Dependent first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Child Other: _____

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

Dependent first name: _____ MI: _____ Last Name: _____

Social Security number: _____ Birth date: ____/____/____

Gender: Male Female

Relationship: Child Other: _____

Medical Dental

Dental ID number: _____ (First-time Guided Dental HMO enrollees only).

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