

Enrollment Form for Health and Dental Coverage

Personal Plans

This application is used only for circumstances where:

- Health coverage is being requested for an individual under the age of 19, or
- Dental only coverage is being requested.

Individuals under the age of 19 applying for medical coverage only (or medical and dental) do not require evidence of insurability. **For individuals age 19 and older requesting medical coverage, you must submit an Evidence of Good Health application.**

1. EMPLOYEE INFORMATION

Employee first name: _____ MI: _____ Last: _____

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

Home address: _____

City: _____ State: _____ ZIP Code: _____

Email: _____ Home telephone: (____) _____

Coverage effective date: _____ Hire Date: ____/____/____

2. EMPLOYER INFORMATION

Employer name: _____ Employer account number: _____

Telephone number (____) _____ Fax number (____) _____

Association: _____

Employer Tax ID number (EIN): _____ E-mail address: _____

Employer's physical address: _____

City: _____ State: _____ ZIP Code: _____

Billing address if different from the employer's physical address

Address: _____

City: _____ State: _____ ZIP Code: _____

Number of full-time and part-time employees currently on the payroll:

- 1-19 employees 20-99 employees more than 100 employees

3. SELECT A MEDICAL PLAN OPTION (UNDER AGE 19 ONLY)

Health Choice 5000* Health Choice 500

Health Choice 3000* Health Today

Health Choice 2000 Basic Health 5000*

Health Choice 1000 Health Saver 2800

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

3. SELECT A DENTAL PLAN OPTION

Premier Dental Care Plan Choice Dental Care Plan

Guided Dental HMO Plan (Available in selected states only. If selecting this plan, indicate a dental facility ID number in the chart on the next page for each covered family member.)

Continued on other side



Employee name: _____ Social Security number: _____

4. LIST ALL FAMILY MEMBERS TO BE COVERED

Last name	First name	Social Security number	Relationship	Birth date	Male/female	Dental ID # Guided Dental HMO Plan

5. COMPLETE SIGNATURE INFORMATION BELOW

Employee signature: _____ Date: ____/____/____

6. EMPLOYEE VERIFICATION

Employee first name: _____ MI: _____ Last: _____

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

Employment date: ____/____/____ Occupation: _____

The undersigned employer representative confirms that this applicant is a paid employee of the above name organization, working 20 or more hours per week, and that the reported salary, if provided, is accurate. We understand that the addition of the products being requested by this applicant, upon approval, will be added to our employer's monthly billing statement. **(The employer representative cannot be the applicant.)**

Signature of employer representative: _____ Date: ____/____/____

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

FOR DEPENDENT(S), COMPLETE THE CERTIFICATE OF DEPENDENT ELIGIBILITY FORM

Return this Authorization to: GuideStone Financial Resources, SBC
Insurance Operations – Personal Plans
2401 Cedar Springs Road
Dallas, TX 75201-1498

Or fax this form to: 214-720-4676

GUIDESTONE USE ONLY

Coverage effective date: ____/____/____ Letter ____

Approved by: _____ Date approved: ____/____/____