

Special Enrollment Form for Medical 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.

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 60 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.

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

GENERAL INFORMATION

Employer name: _____ Employer number: _____

Employer city: _____ State: _____ ZIP code: _____

Employee first name: _____ MI: _____ Last: _____

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

Gender: Male Female

Marital status: Single Married

Employee address: _____ City: _____ State: _____ Zip code: _____

Email: _____ 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 you and/or your dependent(s):

Loss of other health care coverage (indicate specific reason) Date of event: ____/____/____

Retirement End of COBRA eligibility Employer stopped contributions

Death Divorce Termination of employment Other: _____

Dependent addition (indicate specific addition) Date of event: ____/____/____

Marriage Birth Adoption Placement for adoption

If adding a dependent please indicate if you would like to add life and/or dental coverage for Special Enrollee(s):

Spouse life Child life Dental

Email to: Your Group Plans Support Team or
Group.Insurance@GuideStone.org

Continued on other side



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

COVERAGE REQUESTED

Check one:

- | | | | |
|---------------------------------------|--------------------------|--------------------------------------|--------------------------|
| Health Legacy 200 ¹ | <input type="checkbox"/> | Value Health 5000 ^{2,3} | <input type="checkbox"/> |
| Health Today | <input type="checkbox"/> | Secure Health™ 3000 ^{2,3} | <input type="checkbox"/> |
| Health Choice 500 | <input type="checkbox"/> | Health Saver 1500 | <input type="checkbox"/> |
| Health Choice 1000 | <input type="checkbox"/> | Health Saver 2000 | <input type="checkbox"/> |
| Health Choice 1500 | <input type="checkbox"/> | Health Saver 2750 ² | <input type="checkbox"/> |
| Health Choice 2000 | <input type="checkbox"/> | Health Saver 2800 ² | <input type="checkbox"/> |
| Health Choice 2500 ² | <input type="checkbox"/> | Health Saver 3000 ² | <input type="checkbox"/> |
| Health Choice 3000 ² | <input type="checkbox"/> | Health Saver 4000 ² | <input type="checkbox"/> |
| Health Choice 3000 80/20 ² | <input type="checkbox"/> | Health Saver 5000 ² | <input type="checkbox"/> |
| Health Choice 3500 80/20 ² | <input type="checkbox"/> | Economy Health 5000 ² | <input type="checkbox"/> |
| Health Choice 4000 ² | <input type="checkbox"/> | Basic Value Health 5000 ² | <input type="checkbox"/> |
| Health Choice 5000 ² | <input type="checkbox"/> | NC Local Health™ 3000 ² | <input type="checkbox"/> |
| Health Choice 5000 80/20 ² | <input type="checkbox"/> | Global Core 3500 ² | <input type="checkbox"/> |
| Health Choice 6000 ² | <input type="checkbox"/> | Global Core 5000 ² | <input type="checkbox"/> |

Note: Please complete and submit both this form and the *Medicare-coordinating Plans - Retiree Enrollment (Group Plans)* form if you are selecting a Medicare-coordinating plan. The coverage effective date depends on the date these forms are received.

¹This plan is open only to employers who currently have employees participating in the plan.

²This plan does not constitute "creditable coverage" for Massachusetts residents.

³This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older. Participants in this plan could incur late enrollment penalties from Medicare.

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 under age 26.

COMPLETE SIGNATURE INFORMATION BELOW

I hereby request for 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: ____/____/____



5005 LBJ Freeway, Ste. 2200, Dallas, TX 75244-6152
 1-844-INS-GUIDE • GuideStoneInsurance.org

Copy this form as needed.