# Group Plans Enrollment Form

Reset Form

## A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Employer number: _____

Employee name: Last: _____ First: _____ MI: _____

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

Home address: _____

City: _____ State: _____ ZIP code: _____

Daytime telephone: (_____) _____ Email: _____

Sex: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single Employee classification: _____

Monthly salary: _____ Date of full-time employment: _____/_____/_____ Coverage effective date: _____/_____/_____

## B. BENEFIT ELECTION

### Term Life Insurance

Employee life (employer base) ☐ Yes ☐ No

Amount*: $ _____

Employee optional life insurance ☐ Yes ☐ No

GI amount***: $ _____

UW amount**: $ _____

Spouse life insurance (employer base) ☐ Yes ☐ No

Spouse optional life insurance** ☐ Yes ☐ No

Child life insurance ☐ Yes ☐ No

*If employer base life salary multiple is greater than four, *Evidence of Good Health Application* is required.
**Requires *Evidence of Good Health Application* in multiple of salary over $50,000 or a flat $100,000.
***Guaranteed Issue in flat amounts $10,000–$50,000 in $5,000 increments or multiple of salary up to $50,000.

**AD&D** ☐ Yes ☐ No

### Disability Plans

**Short-term Disability** ☐ Yes ☐ No

- ☐ Economy Short Term Disability Plan
- ☐ Choice Short Term Disability Plan
- ☐ Premier Short Term Disability Plan

**Long-term Disability** ☐ Yes ☐ No

- ☐ Economy Long Term Disability Plan
- ☐ Choice Long Term Disability Plan
- ☐ Premier Long Term Disability Plan

### Supplemental Accidental Death & Dismemberment

For myself ☐ Yes ☐ No

Amount: $ _____

For my spouse ☐ Yes ☐ No

Amount: $ _____ (50% of employee volume)

**If you are waiving Employer Paid Medical and/or Dental, please complete Waiver on other side.**

### Medical Benefits

For myself ☐ Yes ☐ No
For spouse ☐ Yes ☐ No
For eligible children ☐ Yes ☐ No

**Coverage** (check one):

- ☐ Health Legacy 200
- ☐ Health Today
- ☐ Health Choice 500
- ☐ Health Choice 1000
- ☐ Health Choice 1500
- ☐ Health Choice 2000
- ☐ Health Choice 2500[1]
- ☐ Health Choice 3000[1]
- ☐ Health Choice 3000 80/20[1]
- ☐ Health Choice 3500 80/20[1]
- ☐ Health Choice 4000[1]
- ☐ Health Choice 5000[1]
- ☐ Health Choice 5000 80/20[1]
- ☐ Value Health 5000[1,2]
- ☐ Secure Health 3000[1,2]
- ☐ Health Saver 1500
- ☐ Health Saver 2000
- ☐ Health Saver 2750[1]
- ☐ Health Saver 2800[1]
- ☐ Health Saver 3000[1]
- ☐ Health Saver 4000[1]
- ☐ Health Saver 5000[1]
- ☐ Economy Health 5000[1]
- ☐ NC Local Health 3000[1]
- ☐ Global Core 3500[1]
- ☐ Global Core 5000[1]

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

**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.**

### Dental Plans

For myself ☐ Yes ☐ No
For spouse ☐ Yes ☐ No
For eligible children ☐ Yes ☐ No

**Coverage** (check one):

- ☐ Premier Dental Care Plan
- ☐ Choice Dental Care Plan
- ☐ Cigna Dental Care DHMO Plan*

*Dental ID number required; please provide on page 2.

**Continued on other side**

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Employee name: _____ Social Security number: _____

## C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

An eligible spouse is a person of the opposite biological sex to whom you are legally married at the relevant time by civil or religious ceremony effective under the laws of the state in which the marriage was contracted.

An eligible dependent child is a person under age 26 (unless 26 and over and permanently incapacitated), that is dependent on you or your spouse for support or maintenance and includes the following:

- Biological child
- Foster child
- Child who you or your spouse must cover pursuant to a court or agency order or National Medical Support Notice under federal law
- Adopted child/placed in home for adoption
- Child 26 or over that is permanently incapacitated
- Stepchild
- Grandchild
- Child for whom you or your spouse is the legal guardian or managing conservator

| Last name | First name | MI | Social Security number | Relationship | Birth date | Sex M/F | Medical Yes/No | Dental Yes/No | ID number (Cigna Dental Care DHMO only) |
|---|---|---|---|---|---|---|---|---|---|
| | | | ——— | Self | ——— | — | | | |
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*Your spouse and children up to age 26 are eligible for coverage.

☐ I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s), and Guide Stone may require reimbursement for claims paid on behalf of ineligible enrollees.

## D. WAIVER OF MEDICAL AND/OR DENTAL COVERAGE

**For new Group Plans participants:** If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical and/or dental coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

**I waive medical coverage for:**

☐ Myself ☐ All eligible dependents
☐ Myself and all eligible dependents ☐ Only these dependents:

**I waive dental coverage for:**

☐ Myself ☐ All eligible dependents
☐ Myself and all eligible dependents ☐ Only these dependents:

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

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

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

**Continued on next page**

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that waiting periods and other limitations may apply.

**Special enrollees for medical coverage:** Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

**Note:** Please see the plan booklets for information about waiting periods and other limitations for special enrollees.

## E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

**Employee signature:** _____ **Date:** _____/_____/_____

**Employer representative:** _____ **Date:** _____/_____/_____

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