RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION –
EMPLOYER MUST COMPLETE THIS SECTION. Unsigned or Incomplete forms will be returned and may delay enrollment.

Employer Name	Group Number	Date of Hire	Effective Date of Change

Certified by (Authorized Representative)	Date	Employer Telephone

Special Instructions:

ENROLLMENT CHANGE SECTION **Effective Date of Change**_____/_____/_____ **(indicate changes below)**
EMPLOYEE INFORMATION – EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)

Employee Name Last	First	MI	Sex ☐ M ☐ F	Date of Birth	Social Security Number

☐ **Employee Name** From: _____ To: _____

☐ **Employee Address** From: _____ To: _____

☐ **Employee Phone** From: _____ To: _____

☐ **Employee Email** From: _____ To: _____

☐ **Marital Status** From: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced. To: ☐ Single ☐ Married ☐ Civil Union Termination ☐ Divorced

☐ **Termination** Choose Reason

☐ Active ☐ Reduction In Hours ☐ Leave of Absence
☐ Lay Off ☐ Medicare Entitlement ☐ Terminate Employment
☐ Death ☐ Marriage ☐ Divorce
☐ Retired ☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Other _____

You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.

☐ **Dependent Status**
(When adding or terminating a dependent you must complete Dependent Section on the reverse side.)

☐ **Add Dependent(s)**
Reason for Addition:
☐ Newborn ☐ Adoption
☐ Marriage ☐ Divorce
☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Newly Eligible Dependent
☐ Other _____

☐ **Terminate Dependent(s)**
Reason for Termination:
☐ Ineligible Child
☐ Marriage ☐ Divorce
☐ Civil Union ☐ Civil Union Termination
☐ Open Enrollment
☐ Death
☐ Other _____

EMPLOYEES: You must check one box in each column below:

Medical
Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event.
Instruction: Enter the Plan Name/Coverage Type in which you are selecting to enroll or change. Only populate if you are changing your medical plan option or coverage type. Check "No Change Medical" if no medical changes are being made.
Enter Plan Name Here:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child or Children
☐ Family
☐ Terminate Medical
☐ No Change Medical

Voluntary Teladoc

☐ Employee Only
☐ Terminate
☐ No Change

Voluntary Dental
Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.
TO: ☐ High ☐ Low

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Dental
☐ No Change Dental

Voluntary Vision
Changes to voluntary vision plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.
TO:

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Vision
☐ No Change Vision

Basic Life – **All life insurance terminates upon employment termination or retirement.**

☐ Add Basic Life (Only available when employee is newly eligible.)
☐ Term Basic Life
☐ No Change

Optional Life – **Changes in Optional Life coverage must be submitted using the BCBS Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org.**

EMPLOYEES: Check all boxes that apply:
☐ Add Optional Employee (Evidence of Insurability REQUIRED)
☐ Add Optional Spouse (Evidence of Insurability REQUIRED)
☐ Add Optional Dependent (Evidence of Insurability REQUIRED)
☐ Terminate Optional Employee
☐ Terminate Optional Spouse
☐ Terminate Optional Dependent
☐ No Change Optional Life

DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number	You must check one box in each line below for each dependent listed.
1.					**Medical** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
2.				- -	**Medical** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
3.				- -	**Medical** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
4.				- -	**Medical** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
5.					**Medical** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline

BASIC LIFE – CHANGE Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.
Street Address			City	State	Zip

OPTIONAL LIFE – CHANGE Beneficiary

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's Social Security Number.
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, vision, or dental plan? ☐ Yes ☐ No

If yes, type(s) of coverage: ☐ Medical ☐ Vision ☐ Dental

Name of individual with other coverage:

_____

Name of employer providing coverage:

_____

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No

Effective Date _____

Name of insurance carrier or TPA:_____Group No._____

Address:_____

_____

Phone:_____Effective Date of other coverage:_____

ADDITIONAL CHANGES – Please add any comments concerning your changes.

Please read, sign, and date the following Authorization & Acknowledgement

- I have read and understand the information provided in the summary of benefits and other enrollment materials.
- On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law.
- Are you declining any coverage due to coverage in another plan? ☐ Yes ☐ No
  If yes, is the other coverage COBRA? ☐ Yes ☐ No ☐ Other (Please Explain)_____

To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.

Employee's Signature	Date:

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE