CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

Enrollment/Change Form

51+ EMPLOYEES

1. EMPLOYER NAME: _____ **Pending Paperwork Number**_____

Employer Group Number: _____ **Division Name:** _____

Enrollment
- ❑ New Group
- ❑ New Employee
- ❑ Existing Employee; Newly Eligible
- ❑ Existing Employee; SPECIAL ENROLLMENT
- ❑ Rehired/Reinstatement of Coverage
- ❑ Open Enrollment

Change (indicate reason) Effective Date _____
- ❑ Add Dependent
  - ❑ Marriage/Civil Union ❑ Birth/Adoption
  - ❑ Loss of other coverage (attach Proof of Loss)
- ❑ Remove Dependents
- ❑ Open Enrollment
- ❑ Beneficiary Change
- ❑ Other

Termination of Coverage
Effective Date _____
- ❑ Termination of employment
- ❑ Waiving all coverage
- ❑ Dropping coverage. Cancel only the following coverages:
  - ❑ Group Basic Life ❑ Vol. Life
  - ❑ Vol. Dep. Life ❑ STD ❑ LTD
  - ❑ Dental ❑ Vision

Continuation-of-Coverage Effective Date _____
- ❑ Termination of Employment/Loss of Eligibility
- ❑ Death of Covered Employee
- ❑ Divorce or Legal Separation
- ❑ Dependent Child Limiting Age
- ❑ Loss of Dependent Coverage when Employee Became Entitled to Medicare
- ❑ Medicare eligibility

2. Employee information—please print clearly and complete the entire form

Employee Name		Email	
Street Address Apt #	Home Telephone ( )	Work Telephone ( )	# of hours worked per week: _____
	Employee date of Hire/Rehire/Retirement	Part-time to Full-time Employment Date	Are you: ❑ Actively at work ❑ COBRA ❑ Retired
City, State, ZIP	Marital status ❑ Single ❑ Married	Effective Date:	

3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR CHANGED

Name (Last Name, First Name, Middle Initial)	Sex	Birth date MM/DD/YY	Social Security #	Group Basic Life	STD	LTD	Voluntary Life	Voluntary Dep. Life	Voluntary Dental	Voluntary Vision
Employee	❑ M ❑ F									
Spouse*	❑ M ❑ F									
Child	❑ M ❑ F									
Child	❑ M ❑ F									
Child	❑ M ❑ F									

* Includes civil unions and domestic partners

4. GROUP BASIC LIFE

❑ Waive
❑ Elect $_____

If life amount is salary-based, enter your annual salary:
$_____

5. VOLUNTARY LIFE

❑ Waive
❑ Elect $_____ OR _____ x salary

If life amount is salary-based, enter your annual salary:
$_____

Amounts over $100,000 require a Personal Health Application.

Beneficiaries

This is the only record of your beneficiary designation. Please retain a copy and give a copy to your employer to submit at the time of request for death benefits.

Group Basic Life Beneficiary Name:
_____

Relationship:
_____

Voluntary Life Beneficiary Name:
_____

Relationship:
_____

6. VOLUNTARY DEPENDENT LIFE

❑ Waive
❑ Spouse
Amount $_____ (Amounts over $50,000 require a Personal Health Application.)
❑ Child(ren)
❑ Both

7. STD/LTD

❑ Waive STD ❑ Elect STD
❑ Waive LTD ❑ Elect LTD*
Annual salary $_____
* Not available to employees who work fewer than 30 hours per week

8. VISION

❑ Waive ❑ Elect

9. DENTAL - Ameritas

❑ Waive
❑ Passive PPO 100%/80%/0%–$750
❑ Passive PPO 100%/50%/50%–$750
❑ Active PPO 100%/80%/50%–$1,000
❑ Passive PPO 100%/80%/50%–$1,000
❑ Passive PPO 100%/80%/50%–$1,500 with ortho

10. AUTHORIZATION AND ACCEPTANCE

I hereby apply for the carrier and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required premium, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's and employer's signatures are required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

If you're declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, civil union, domestic partner, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, civil union, domestic partner, birth, adoption or placement for adoption.

_____ _____
Employer Signature Date

_____ _____
Employee Signature Date

Eff. 5/16

Employer—Please retain a copy for your files

CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

Enrollment Instructions

- Check with your employer for available benefit options.
- Complete all items to avoid delays in processing.
- Please complete all sections including date of birth, Social Security Number and sections indicating the amount of life insurance selected, your salary—if life is salary-based, and your beneficiary. Note: If you do not elect Life, STD or LTD at the time you are first eligible, you will be required to complete and provide a Personal Health Application.
- Your signature and date **and** your employer's signature and date must be on the Enrollment/Change Form.
- Covered dependents enrolled in ancillary coverages are eligible to age 26.
- For dental enrollment (section 9), choose one plan.
- An affidavit may be required at time of claim to verify domestic partner relationship. See cbia.com for a copy of the affidavit.

Thank you for selecting coverage through CBIA Health Connections.