Employee Enrollment for Group Health Coverage

Mennonite Educators Benefit Plan

This enrollment form is for self-funded coverage provided by your employer.

1. MEBP employer _____
2. Location _____
   city state
3. Employee _____
   first middle last
4. Social Security number _____
5. First day of work _____
6. Number of hours worked per week _____

To waive coverage

To waive health coverage, this section must be completed and signed.

7. ☐ I waive health coverage for
   ☐ myself ☐ my spouse ☐ my dependents
8. I (we) have other creditable health coverage through
   ☐ a group health plan
   ☐ health insurance coverage, such as individual coverage
   ☐ Part A or Part B of Title XVIII of the Social Security Act
   ☐ Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928
   ☐ Chapter 55 of Title 10, United States Code
   ☐ a medical care program of the Indian Health Service or of a tribal organization
   ☐ a state health benefits risk pool
   ☐ a health plan offered under Chapter 89 of Title 5, United States Code
   ☐ a public health plan established or maintained by a state, the U.S. government, or a foreign country
   ☐ a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))
   ☐ Title XXI of the Social Security Act (State Children's Health Insurance Program)
9. Are all family members on the same plan? ☐ yes ☐ no
   If **no**, please explain.

   _____

   _____

Having waived coverage, I understand I have the opportunity to enroll myself or my dependents later if I (we) lose other creditable coverage due to certain qualifying events which are outlined in the attached notice. I further understand that I (we) must enroll in the plan within the designated special enrollment period that immediately follows a qualifying event. If I (we) do not enroll within the special enrollment period, I (we) will be considered a late enrollee(s)*.

_____

Signature Date

**Late enrollees are eligible to enroll only during the annual open enrollment period of April 15 to May 15.*

To enroll in coverage

10. ☐ I request health coverage for
    ☐ myself ☐ my spouse ☐ my dependents
11. Employee address _____
    street

    _____
    city state ZIP
12. Telephone number: _____
    Daytime (if different)_____
13. Email address _____
14. Birth date _____ 15. Age _____
    month day year
16. Gender ☐ M ☐ F
17. Marital status ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
18. Job title _____
19. Please give reason for **initial** enrollment.
    ☐ new hire as of _____ *(date)*
    ☐ change in hours as of _____ *(date)*
    ☐ loss of previous creditable coverage as of _____ *(date)*
    ☐ marriage, birth or adoption of child as of _____ *(date)*
    ☐ loss of Medicaid/CHIP eligibility as of _____ *(date)*
    ☐ eligible for premium assistance subsidy under Medicaid or CHIP as of _____ *(date)*
    ☐ change in employment status as of _____ *(date)*
    ☐ open enrollment

20. If you are adding family members to **an existing policy**, check the appropriate box and provide the dates requested.
    - ☐ Adding spouse; reason
        - ☐ loss of previous creditable coverage as of _____ *(date)*
        - ☐ marriage as of _____ *(date)*
        - ☐ birth or adoption of child as of _____ *(date)*
    - ☐ Adding new dependents
      reason for adding them at this time _____
      _____
        - ☐ loss of Medicaid/CHIP eligibility as of _____ *(date)*
        - ☐ eligible for premium assistance subsidy under Medicaid or CHIP as of _____ *(date)*
        - ☐ open enrollment

Spouse and dependents (complete if to be covered)

21. Name (first, middle, last)	**Social Security Number**	**Birth Date (month, day, year)**	**Gender**
Spouse			
Dependent			
Dependent			
Dependent			

22. If you and the other parent of the dependents listed above are divorced or separated,
    a. who has custody of the dependents? _____
    b. who has financial responsibility for health expenses? _____

Other medical insurance

23. Will anyone named on this enrollment form continue to have health coverage with another insurer after this plan goes into effect? ☐ yes *(give details below)* ☐ no

24. Will this coverage replace an existing health insurance policy for anyone named on this enrollment form?
    ☐ yes *(give details below)* ☐ no

Persons Covered	**Name of Other Health Insurance**	**Is this an Employer-Provided Policy?**	**To be Replaced?**	**Date of Replacement**
		☐ yes ☐ no	☐ yes ☐ no	
		☐ yes ☐ no	☐ yes ☐ no	

Employee authorization

I certify that the above information is true and correct. I am responsible to notify my employer of any changes in the above information. I authorize the deduction from my earnings of the amount required to cover my share of the contributions. I reserve the right to cancel this request in writing. I authorize all health care providers to release any necessary medical information to Everence and the claims administrator to certify medical treatment or process claims for myself, my spouse, or my dependents. I understand that Everence and the claims administrator will share this information with third parties only if necessary for precertification, managing claims, or processing claims.

_____

Employee's signature Date

For employer use only
The individual(s) requesting enrollment have been determined by the employer to be eligible for plan coverage. I authorize this enrollment.

Health plan effective date _____

_____
Signature of plan representative

Notice of Special Enrollment Rights

Mennonite Educators Benefit Plan

Everence Insurance Company has prepared this notice on behalf of your health plan.

If you or your dependents are eligible for coverage under the Mennonite Educators Benefit Plan but choose not to enroll, you may have special rights to enroll at a later time without being considered a late enrollee, as outlined below.

Termination of employer contributions and loss of eligibility for other creditable coverage

If you and/or your dependents waive coverage under this plan because you are enrolled in other creditable coverage[1], you and/or your dependents may enroll in this plan later without being considered a late enrollee if employer contributions toward the other health coverage terminate or if eligibility for the other creditable coverage is lost as a result of any of the following qualifying events:

- Termination of employment
- Involuntary termination of the other health coverage
- Reduction in the number of hours of employment
- Change in marital status such as marriage, legal separation, divorce, or death
- The other health coverage discontinues dependent coverage

You or your dependents must enroll in this plan within the 30-day special enrollment period that immediately follows the day the other creditable coverage ends (or employer contributions terminate).

When new dependents become eligible for coverage

If you and your dependents choose not to enroll in this plan, you and your dependents may enroll later without being considered a late enrollee at the same time a new dependent becomes eligible to be covered under the plan because of marriage, birth, or adoption. You and your dependents must enroll in this plan within the 30-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

In the same way, if your spouse and dependents choose not to enroll in this plan, they may enroll later without being considered late enrollees at the same time a newborn or newly adopted child becomes eligible to be covered under the plan. Your spouse and dependents must enroll in this plan within the 30-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

Special enrollment rights under Children's Health Insurance Program Reauthorization Act of 2009

If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents may enroll in this plan later without being considered a late enrollee if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible but choose not to enroll in this plan, you and/or your dependents may enroll in this plan later without being considered a late enrollee if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP which provides help in paying for coverage under this plan.

You and/or your dependents must enroll in this plan within the 60-day special enrollment period that immediately follows the date coverage under Medicaid or CHIP terminates or the date it is determined that you and/or your dependents are eligible for a state premium assistance subsidy, whichever applies.

Enrolling at any other time

Any eligible individual who does not enroll in this plan within his or her respective enrollment or special enrollment period will be considered a late enrollee. A late enrollee will only be eligible to enroll in the plan during the annual open enrollment period that begins April 15 and ends May 15. Coverage will begin July 1.

To request special enrollment

To request special enrollment or obtain additional information, contact your employer's Human Resources Department.

[1] Creditable coverage includes a group health plan; health insurance coverage, including individual coverage; Parts A or B of Title XVIII of the Social Security Act (Medicare); Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan under Chapter 89 of Title 5, United States Code; a public health plan established or maintained by a state, the U.S. government, or a foreign country; a health benefit plan under Section 5(e) of the Peace Corps Act (22 U. S. C.2504(e)); or Title XXI of the Social Security Act (State Children's Health Insurance Program).

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Employee – keep this copy for your records.