Employee Enrollment for Group Health Coverage Mennonite Educators Benefit Plan

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TINS CIN OMMERCIAL TOTAL	is for self farfaca	coverage provided by	your ciliployer.

1. MEBP employer	4. Social Security number 5. First day of work			
2. Location state				
3. Employee	6. Number of hours worked per week			
first middle last				
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	☐ 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 (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.			
□ 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))				
To enroll in coverage				
10. ☐ I request health coverage for ☐ myself ☐ my spouse ☐ my dependents 11. Employee address	18. Job title			
city state ZIP 12. Telephone number: Daytime (if different) 13. Email address 14. Birth date 15. Age month day year	of			
 16. Gender □ M □ F 17. Marital status □ single □ married □ widowed □ separated □ divorced 				

20. If you are adding family members to an existing policy , check the appropriate box and provide the dates requested.				Adding new dependents reason for adding them at this time				
Adding spouse; reason loss of previous creditable coverage as of(date) marriage as of(date) 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) ☐ open enrollment					
Sp.		(date) ts (complete if to be covere	ed)					
21	. Name (first, middle, last)		Social	Security Number	Birth Date (month, day, y		Gender	
Sp	ouse							
De	pendent							
De	pendent							
De	pendent							
22.	If you and the other pare	nt of the dependents listed above a	are divorc	ed or separated,				
	a. who has custody of th	e dependents?						
	b. who has financial resp	onsibility for health expenses?						
Ot	her medical insuran	ce						
	into effect? ☐ yes (giv	is enrollment form continue to have details below) one no		-		his pla	n goes	
	Persons Covered	Name of Other Health Insur	ance	Is this an Employer-Provide Policy?	ed To be Replaced?		ate of acement	
				□ yes □ no	□ yes □ no			
				□ yes □ no	□ yes □ no			
I ce info I res info or r	ormation. I authorize the d serve the right to cancel th ormation to Everence and t my dependents. I understa	pation is true and correct. I am responded action from my earnings of the action request in writing. I authorize all the claims administrator to certify mand that Everence and the claims admin, managing claims, or processing of	amount re health ca nedical tre ministrate	equired to cover my are providers to relea eatment or process o	share of the con use any necessary claims for myself	itributi y medi , my sp	ons. cal pouse,	
Emp	loyee's signature	Date	For emp	loyer use only				
			The indiv	The individual(s) requesting enrollment have been determined by the employer to be eligible for plan coverage. I authorize this enrollment.				
			Health p	an 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 coverage¹, 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

Everence Insurance Company

1110 N. Main St. P.O. Box 483 Goshen, IN 46527 everence.com Toll-free: (800) 348-7468 T: (574) 533-9511 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).

Employee – keep this copy for your records.