



# Egyptian Area Schools Employee Benefit Trust

## CHANGE ENROLLMENT FORM

**EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION** (Employer Representative – Unsigned or Incomplete forms will be returned and may delay enrollment) **(For Employer Use Only) – Retain a copy for your records.** Confirmation No. \_\_\_\_\_

Employer Name	Group Number	Date of Hire	Effective Date of Change
Certified by (Authorized Representative)	Date	Employer Telephone	

**Employers please indicate which Health Plan options your district offers:**

Plan A   
  Plan B   
  Plan C   
  HDHP   
  Plan E1   
  All Plans

Enter information at [www.meritain.com](http://www.meritain.com) or

**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	Date of Birth	Social Security Number
				<input type="checkbox"/> M <input type="checkbox"/> F		

Will Employee be Medicare Eligible at age 65?     Yes     No

**Employee Name**    From: \_\_\_\_\_ To: \_\_\_\_\_

**Employee Address**    From: \_\_\_\_\_ To: \_\_\_\_\_

**Employee Phone**    From: \_\_\_\_\_ To: \_\_\_\_\_

**Employee Email**    From: \_\_\_\_\_ To: \_\_\_\_\_

**Employee Certification**    From:  Yes     No    To:  Yes     No

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

<input type="checkbox"/> <b>Termination</b> Choose Reason <input type="checkbox"/> Active <input type="checkbox"/> Reduction In Hours <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Lay Off <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Retired <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____ You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.	<input type="checkbox"/> <b>Dependent Status</b> (When adding or terminating a dependent you must complete Dependent Section on the reverse side.) <input type="checkbox"/> <b>Add Dependent(s)</b> Reason for Addition: <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible Dependent <input type="checkbox"/> Other _____	<input type="checkbox"/> <b>Terminate Dependent(s)</b> Reason for Termination: <input type="checkbox"/> Ineligible Child <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Death <input type="checkbox"/> Other _____
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**EMPLOYEES: You must check one box in each column below:**

<b>Medical</b> Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event. You may only change to a higher level of benefits with a 12 month notice to your employer. EMPLOYERS: ATTACH A COPY OF 12 MONTH NOTICE TO CHANGE FORM. TO: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan E1 <input type="checkbox"/> Plan C <input type="checkbox"/> HDHP	<b>Voluntary Teladoc</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Terminate <input type="checkbox"/> No Change	<b>Voluntary Dental</b> Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event. TO: <input type="checkbox"/> High <input type="checkbox"/> Low	<b>Voluntary Vision</b> Changes to voluntary vision plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event. TO:
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Terminate Medical <input type="checkbox"/> No Change Medical	<input type="checkbox"/> Employee Only <input type="checkbox"/> Terminate <input type="checkbox"/> No Change	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Dental <input type="checkbox"/> No Change Dental	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Vision <input type="checkbox"/> No Change Vision

**Basic Life – All life insurance terminates upon employment termination or retirement.**    **Optional Life – Changes in Optional Life coverage must be submitted using the Dearborn National Evidence of Insurability form unless you are terminating coverage. Form can be found at [www.egtrust.org](http://www.egtrust.org).**

<input type="checkbox"/> Add Basic Life (Only available when employee is newly eligible.) <input type="checkbox"/> Term Basic Life <input type="checkbox"/> No Change	<b>EMPLOYEES: Check all boxes that apply:</b> <input type="checkbox"/> Add Optional Employee (Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Employee <input type="checkbox"/> Add Optional Spouse (Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Spouse <input type="checkbox"/> Add Optional Dependent( Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Dependent <div style="text-align: right;"><input type="checkbox"/> No Change Optional Life</div>
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**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.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
2.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
3.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
4.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> 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 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 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 insurance carrier or TPA: \_\_\_\_\_ Group No. \_\_\_\_\_

Address: \_\_\_\_\_

Name of employer providing coverage: \_\_\_\_\_

Is other coverage Medicare or Medicaid?  Yes  No Phone: \_\_\_\_\_ Effective Date of other coverage: \_\_\_\_\_

Effective Date \_\_\_\_\_

**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:
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