



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 _____ Department Number _____ Date of Hire ____/____/____ Effective Date of Change ____/____/____

Certified by (Authorized Representative) _____ Date ____/____/____ Employer Telephone (____) _____-____

Employers please indicate which Health Plan options your districts offers:
 Platinum Gold Silver Bronze All Plans

Enter information at www.meritain.com or
 Mail to: MERITAIN HEALTH
 300 CORPORATE PARKWAY
 AMHERST, NEW YORK 14226

ENROLLMENT CHANGE SECTION Effective Date of Change ____/____/____ (indicate changes below)

EMPLOYEE INFORMATION – COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)
 Submit a copy of certificate of creditable coverage with this form. Please check if no prior coverage.

Employee Name Last First MI Sex Date of Birth Employee ID No. - REQUIRED
 M F ____/____/____

Will Employee be Medicare Eligible at age 65? Yes No

Employee Name From: _____ To: _____
 Employee Address From: _____ To: _____
 Employee Phone From: _____ To: _____
 Marital Status From: Single Married Divorced To: Single Married Divorced

<input type="checkbox"/> Termination Choose Reason	<input type="checkbox"/> Dependent Status (When adding or terminating a dependent you must complete Dependent Section on the reverse side.)
<input type="checkbox"/> Active <input type="checkbox"/> Reduction In Hours <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Death <input type="checkbox"/> Open Enrollment Period <input type="checkbox"/> Divorce <input type="checkbox"/> Retired <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____	<input type="checkbox"/> Add Dependent(s) Reason for Addition: <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Newly Eligible Full-time Student <input type="checkbox"/> Marriage <input type="checkbox"/> Open Enrollment Period <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"/> Terminate Dependent(s) Reason for Termination: <input type="checkbox"/> Ineligible Child <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Open Enrollment Period <input type="checkbox"/> Death <input type="checkbox"/> Other _____

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

Medical Plan 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"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze	Voluntary Dental Plan. 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	Vision 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"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Dental <input type="checkbox"/> No Change Dental Note: Effective date of coverage is 1st day of month following your date of hire or 1st day of month following Annual Enrollment Period.	<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 will automatically terminate upon employment termination or retirement. **Optional Life** – Changes in Optional Life coverage must be submitted using the Lincoln Financial Group Evidence of Insurability form unless you are terminating coverage.

<input type="checkbox"/> Add Basic Life <input type="checkbox"/> Term Basic Life <input type="checkbox"/> No Change	EMPLOYEES: Check all boxes that apply: <input type="checkbox"/> Terminate Optional Employee <input type="checkbox"/> Terminate Optional Dependent <input type="checkbox"/> Terminate Optional Spouse <input type="checkbox"/> 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 ID Number	Full-Time Student? (Y or N)	You must check one box in each line below for each dependent listed.				
						Health <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
1.			/ /	- -		Health <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Dental <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Vision <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
2.			/ /	- -		Health <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Dental <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Vision <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
3.			/ /	- -		Health <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Dental <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Vision <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
4.			/ /	- -		Health <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Dental <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>
						Vision <input type="checkbox"/>	Add <input type="checkbox"/>	Term <input type="checkbox"/>	No Change <input type="checkbox"/>	Decline <input type="checkbox"/>

BASIC LIFE - CHANGE Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's ID No.
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 ID No.
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	

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, dental, or vision plan? Yes No
 If yes, type(s) of coverage: Medical Dental Vision

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: _____

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