



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 Social Security Number. - **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

Termination Choose Reason

Active Reduction In Hours Terminate Employment
 Lay Off Medicare Entitlement Leave of Absence
 Death Open Enrollment Period Divorce
 Retired Marriage
 Other _____

You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.

Dependent Status
 (When adding or terminating a dependent you must complete Dependent Section on the reverse side.)

Add Dependent(s)
 Reason for Addition:
 Newborn
 Adoption
 Newly Eligible Full-time Student
 Marriage
 Open Enrollment Period
 Other _____

Terminate Dependent(s)
 Reason for Termination:
 Ineligible Child
 Marriage
 Divorce
 Open Enrollment Period
 Death
 Other _____

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

Medical Plan **Voluntary Dental Plan** **Voluntary Vision 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: Platinum Gold Silver Bronze TO: High Low TO:

Employee Only Employee Only Employee Only
 Employee + Spouse Employee + 1 Dependent Employee + 1 Dependent
 Employee + Child or Children Employee + 2 or more Dependents Employee + 2 or more Dependents
 Family Terminate Dental Terminate Vision
 Terminate Medical No Change Dental No Change Vision
 No Change Medical

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.**

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