RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

# 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 ☐ 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 – 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 |
|---|---|---|---|---|---|
| | | | ☐ M ☐ 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: ______________________

☐ **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

**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:** ☐ **Plan A** ☐ **Plan B** ☐ **Plan C** ☐ **HDHP**

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child or Children
☐ Family
☐ Terminate Medical
☐ No Change Medical

### Voluntary Teladoc

☐ Employee Only
☐ Terminate
☐ No Change

### Voluntary Dental

**Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.**

**TO:** ☐ **High** ☐ **Low**

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Dental
☐ No Change Dental

### Voluntary Vision

**TO:**

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Vision
☐ No Change Vision

### Basic Life – All life insurance terminates upon employment termination or retirement.

☐ Add Basic Life (Evidence of Insurability REQUIRED)
☐ Term Basic Life
☐ No Change

### Optional Life – Changes in Optional Life coverage must be submitted using the Lincoln Financial Group Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org.

**EMPLOYEES: Check all boxes that apply:**

☐ Add Optional Employee (Evidence of Insurability REQUIRED) ☐ Terminate Optional Employee
☐ Add Optional Spouse (Evidence of Insurability REQUIRED) ☐ Terminate Optional Spouse
☐ Add Optional Dependent( Evidence of Insurability REQUIRED) ☐ Terminate Optional Dependent
☐ 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 | You must check one box in each line below for each dependent listed. |
|---|---|---|---|---|---|
| 1. | | | | - - | **Health** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline |
| 2. | | | | - - | **Health** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline |
| 3. | | | | - - | **Health** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline |
| 4. | | | | - - | **Health** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline<br>**Vision** ☐ Add ☐ Term ☐ No Change ☐ 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

Effective Date ____________________

Phone:____________________________Effective Date of other coverage:__________________

**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