RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

MERITAIN HEALTH

Egyptian Area Schools Employee Benefit Trust

SPECIAL HEALTH PLAN ENROLLMENT - Plans A, B, C or HDHP

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION

Employer Name	Group Number	Date of Hire	Effective Date of Change ☐ 1/1/14 or ☐ 2/1/14 or ☐ 3/1/14
Certified by (Authorized Representative)	Date	Employer Telephone	
The Health Plan option your district offers: ☐ Plan A ☐ Plan B ☐ Plan C ☐ HDHP ☐ All Plans		**Fax completed form to: 888-525-2799**	

ENROLLMENT / CHANGE SECTION **Effective Date of Change:** ☐ 1 / 1 / 2014 **or** ☐ 2 / 1 / 2014 **or** ☐ 3 / 1 / 2014

EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)

Employee Name — Last — First — MI

Employment Status	Sex	Date of Birth	Social Security Number
☒ Active (Available only to Active Employees)	☐ M ☐ F		- -

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS

☐ **I am currently enrolled in an Egyptian Trust Health Plan and would like to continue my coverage WITH changes to my covered dependents. I understand I must remain in the Plan I am currently enrolled in and my dependents must also be enrolled in the same Plan. Changes to Plan is not allowed at this time. Dependents must enroll in the same benefit plan as the employee.**
EMPLOYEE – Please complete all remaining sections of this form.

☐ **I am NOT currently covered under an Egyptian Trust Health Plan but would like to enroll myself and my dependents (if applicable) in the following Plan of benefits. I understand I am enrolling in a Plan my employer offers.**
☐ Plan A ☐ Plan B ☐ Plan C ☐ HDHP
EMPLOYEE – Please complete all remaining sections of this form.

☐ **I am currently enrolled in an Egyptian Trust Health Plan and wish to terminate coverage as noted below consistent with my enrollment or my dependents enrollment in the exchange. I have provided documentation to my employer for myself and/or those dependents terminating this coverage due to enrollment in the exchange.**
EMPLOYEE – Please complete all remaining sections of this form.

EMPLOYEE INFORMATION: Incomplete forms will be returned and may delay enrollment

Employee Home Address — Street/Apt. — City — State — Zip

Marital Status		Home Phone ( ) -	Email Address	Occupation:_____
☐ Married	☐ Divorced			
☐ Single	☐ Widowed	Business Phone ( ) -		Average Hours Worked per Week:_____

MEDICAL – A, B, C, HDHP (Basic Life coverage is automatic when enrolling in an Egyptian Trust Health Plan.)

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family

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	Covered Person's Social Security Number	Check one box for each dependent listed.
1. **Employee**	**Self**			- -	☐ Add ☐ Terminate
2.				- -	☐ Add ☐ Terminate
3.				- -	☐ Add ☐ Terminate
4.				- -	☐ Add ☐ Terminate
5.				- -	☐ Add ☐ Terminate
6.				- -	☐ Add ☐ Terminate
7.				- -	☐ Add ☐ Terminate
8.				- -	☐ Add ☐ Terminate

BASIC LIFE – 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

OTHER INSURANCE COVERAGE

Are you, the **employee,** covered under **any** other group medical insurance plan? ☐ Yes ☐ No

Are any of your **dependents** covered under **any** other medical insurance plan? ☐ Yes ☐ No

If any of your dependents are covered under another medical insurance plan, complete all lines below:

List all family members enrolled in this plan:

_____ _____

_____ _____

_____ _____

_____ _____

Name of employer group or other health plan providing coverage:

_____ Phone No: _____

Name of insurance carrier or TPA (Claims Administrator):

_____ Phone No: _____

Group Name and Number:

_____ Effective date of coverage:_____

Address:

_____

_____

_____

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