RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

NEW ENROLLEE (Not Currently Covered)

EMPLOYER (OR PLAN SPONSOR) SECTION

EMPLOYER MUST COMPLETE THIS SECTION. Unsigned or incomplete forms will be returned and may delay enrollment.

Employer Name	Group Number	Effective Date

Enrollment Event: ☐ Open Enrollment-Applies to medical plan only ☐ Annual Enrollment-Applies to dental plan only ☐ New Hire ☐ Late Enrollment ☐ Qualifying Change in Family Status Reason

Employee Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Other

Date of Hire

Certified by (Authorized Representative) | Date | Employer Telephone ( ) -

Special Instructions:

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	Marital Status	Social Security Number
	☐ M ☐ F		☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Civil Union	

Employee Home Address (Street/Apt., City, State, Zip)

Home Phone _____ Business or Cell Phone _____ | Email Address | Occupation:_____ Average Hours Worked per Week:_____ | Earnings $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Annually

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

Medical Plan Options	Voluntary Teladoc	Voluntary Dental	Voluntary Vision
Instruction: Ask your Employer which Plans you are eligible for. **Enter Plan Name Here:** _____	☐ **Teladoc Only**	☐ **High** ☐ **Low**	
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family ☐ Decline Coverage **NOTE:** Includes Teladoc, Basic Life Insurance and Prescription Coverage	☐ Employee Only ☐ Decline Coverage **NOTE:** Teladoc is included in Medical Plan.	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage

EMPLOYEES: Check all boxes that apply:

Basic Life –
Basic Life is automatic when enrolling in Health Plan

☐ Basic Life Amount _____
☐ Decline coverage

Optional Life –
When applying for more than guarantee issue amounts an Evidence of Insurability form must be completed.

☐ Optional Employee Life Amount _____ Note: Evidence of Insurability Form required for amounts over $100,000
☐ Optional Spouse Life Amount _____ Note: Limited to 50% of Employee Life – Evidence of Insurability required for amounts over $37,500
☐ Optional Dependent Life ☐ $5,000 or ☐ $10,000 Note: Covers all eligible children
☐ Decline Coverage

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 (Required when enrolling dependents.)	Please mark the coverage chosen or decline coverage for each dependent listed.
1.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
2.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
3.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
4.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
5.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline

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 ☐ Vision ☐ Dental

Name of individual with other coverage:_____ Effective Date of other coverage_____

Name of insurance carrier or TPA:_____ Group No. _____

Address:_____ Phone: _____

Name of employer providing coverage: _____

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No Medicare/Medicaid Effective Date of coverage _____

EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE

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 Social Security Number
Street Address			City	State	Zip

OPTIONAL 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 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.

REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE) **Blue Cross Blue Shield of Illinois**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **APPLY FOR THE BASIC GROUP LIFE BENEFITS** indicated above and, if my application is approved by BCBSIL, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.

☐ **WAIVE COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS** indicated above and, if my application is approved by BCBSIL I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.

☐ **WAIVE COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **WAIVE COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of BCBS of IL, and the initial premium is paid to BCBS of IL. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

REQUEST FOR COVERAGE (MEDICAL) **Administered By: Blue Cross Blue Shield of Illinois**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.

☐ **WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program.** I understand that if I apply for coverage at a later date all the rules of late enrollment will apply.

REQUEST FOR COVERAGE (VOLUNTARY TELADOC)

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **I APPLY FOR THE GROUP BENEFITS** indicated above and, I authorize deductions from my pay for any required contributions.

☐ **WAIVER OF COVERAGE: I do NOT want to enroll myself in the Voluntary Teladoc Program.**

REQUEST FOR COVERAGE (VOLUNTARY DENTAL) **Met Life**

Select Coverage. Confirm the options available to you by reviewing your benefit plan description or checking with your employer. Note: Except for COBRA continuance, dependent coverage may be elected only if employee coverage is elected.

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.

☐ **WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program.** I understand that if I apply for coverage at a later date all the rules of late enrollment will apply.

REQUEST FOR COVERAGE (VOLUNTARY VISION) **Met Life**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved I authorize deductions from my pay for any required contributions.

☐ **WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program.**

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