Group Plans Enrollment Form

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: ____________________ Employer number: ____________________

Employee name: Last: ____________________ First: ____________________ MI: __________

Birth date: ______/______/______ Social Security number: ____________________

Home address: ____________________

City: ____________________ State: ________ ZIP code: ____________________

Daytime telephone: (________) ____________________ Email: ____________________

Sex: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single Employee classification: ____________________

Monthly salary: ____________________ Date of full-time employment: ______/______/______ Coverage effective date: ______/______/______

B. BENEFIT ELECTION

If you are waiving Employer Paid Medical, please complete Waiver on other side.

Medical Benefits

For myself	☐ Yes	☐ No
For spouse	☐ Yes	☐ No
For eligible children	☐ Yes	☐ No

Coverage (check one):

☐ Health Saver 2000[1]
☐ Health Saver 3000[1]
☐ Health Saver 5000[1]

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.

Please complete and submit both this form and the *Medicare-coordinating Plans – Retiree Enrollment (Group Plans)* form if you are selecting a Medicare-coordinating plan. The coverage effective date depends on the date these forms are received.

Continued on other side

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Employee name: ______________________________ Social Security number: ______________________

C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	Social Security number	Relationship	Birth date	Sex M/F	Medical Yes/No
		———	Self	———	—	

*Your spouse and children up to age 26 are eligible for coverage.

D. WAIVER OF MEDICAL AND/OR DENTAL COVERAGE

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

- ☐ Myself
- ☐ Myself and all eligible dependents
- ☐ All eligible dependents
- ☐ Only these dependents:

Name: ______________________________ Social Security number (last four digits): ______________

Name: ______________________________ Social Security number (last four digits): ______________

Name: ______________________________ Social Security number (last four digits): ______________

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that waiting periods and other limitations may apply.

Special enrollees for medical coverage: Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

Note: Please see the plan booklets for information about waiting periods and other limitations for special enrollees.

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: ______________________________ **Date:** _____/_____/_____

Employer representative: ______________________________ **Date:** _____/_____/_____

Email to: Your Group Plans Support Team **or** *Group.Insurance@GuideStone.org*

5005 LBJ Freeway, Ste. 2200, Dallas, TX 75244-6152

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