Special and Late Applicant Enrollment Form for Health Care Coverage

Group Plans

This application is used only for circumstances where health care coverage is being requested for an individual after an employee's or dependent's initial eligibility period has passed. If the employee is enrolling in Group Plans for the first time, a Group Plans Enrollment Form **must** accompany this form for enrollment. This form is used for two classifications of individuals:

Special enrollees

If an individual meets one of the following requirements, this person is a Special Enrollee:
- Loss of eligibility for other health care coverage, application for enrollment must be made within 60 days of the event.
- Acquisition of a dependent through marriage, birth, adoption, or placement for adoption, application for enrollment must be made within 60 days of the event.

A Special Enrollee age 19 or older is subject to a 12-month pre-existing condition limitation period, less any creditable coverage.
If approved, the medical coverage will become effective the day of the qualifying event.

Late enrollees

If an individual requests coverage after his initial eligibility period, he is considered a Late Enrollee and will be subject to a 12–month pre-existing condition limitation period, less any creditable coverage. This limitation only applies to those age 19 or older.
If approved, medical coverage will become effective on your group's annual renewal date, following submission of the application.

GENERAL INFORMATION

Employer name: ______________________ Employer number: ______________

Employer city: ______________ State: ______ ZIP Code: ________

Employee first name: ______________________ MI:______ Last: ______________

Social Security number:______________________

Employee address:______________________City: ______________ State: ______ ZIP Code: __________

Email:______________________ Home telephone: (________) ______________

Coverage is being requested for (check all that apply):

☐ Self ☐ Spouse ☐ Dependent children

From the choices below, please indicate the reason coverage is being requested for yourself and/or your dependents:

☐ Loss of other health care coverage (indicate specific reason) Date of event: _______/ _______/ _______

☐ Company out of business ☐ Layoff ☐ Retirement ☐ End of COBRA eligibility

☐ Death ☐ Divorce ☐ Termination of employment ☐ Other: ______________

☐ Dependent addition (indicate specific addition) Date of event: _______/ _______/ _______

☐ Marriage ☐ Birth ☐ Adoption ☐ Placement for adoption

☐ Late enrollment

Return to: GuideStone Financial Resources, SBC
Insurance Operations — Group Plans
2401 Cedar Springs Road
Dallas, TX 75201-1498

Or Fax to: 214-720-2105

Continued on other side

GuideStone® Insurance Plans

Employee name: ______________________________ Social Security number: ______________

COVERAGE REQUESTED (CHECK ONE)

	Check one
Health Legacy 200	☐
Health Today	☐
Health Choice 500	☐
Health Choice 1000	☐
Health Choice 2000	☐
Health Choice 3000	☐
Health Choice 5000	☐
Health Saver 2600	☐
Health Saver 2800	☐
Health Saver 3000	☐

Health Select Plans (out of area)

	Check one
Health Select 200	☐
Health Select 500	☐
Health Select 1000	☐
Health Select 2000	☐
Health Select 3000	☐
Health Select 5000	☐

Note: The Senior Plan Enrollment Form is required for the plans below.
The coverage effective date depends on the date this form is received.

Senior plans: ☐ Senior Plus Plan ☐ Senior Plan ☐ Care Plus Plan ☐ Care Basic Plan

IF YOUR DEPENDENT(S) ARE TO BE COVERED, PROVIDE THE FOLLOWING INFORMATION

Last name	First name	MI	Social Security number	Date of birth	Relationship	Sex M/F

Applicable to your spouse and any children to age 26.

COMPLETE SIGNATURE INFORMATION BELOW

Attach a Certificate of Creditable Coverage from prior health care plan, if applicable.

I hereby request my employer to arrange for the issuance of the benefits to which I am now entitled, or to which I may become entitled under the terms of the group policy or policies issued to and/or administered by GuideStone and I authorize my employer to make the proper deductions, if any, from my earnings as my contribution toward the cost of this insurance.

Employee signature: ______________________________ Date: _______/ _______/ _______

Employer authorized representative: ______________________________ Date: _______/ _______/ _______

FOR GUIDESTONE USE ONLY

Coverage effective date: _____/ _____/ _____ Letter _______ PCL _______

Approved by: ______________________________ Date approved: _____/ _____/ _____

Copy this form as needed.