SPECIAL ENROLLMENT FORM

Applicability

Special Enrollment applies to you and/or your Dependent(s) if you/they are eligible for coverage under your employer's group health plan, and qualify under one of the Special Enrollment conditions described below. If you qualify under one of these conditions, please complete the form on the reverse side and submit to your employer within **31 days** of the Special Enrollment condition. We will review the information provided and notify your employer regarding the status of your coverage.

Note: Special Enrollment applies only to group health plan or other health insurance.

Special Enrollment Conditions

If you previously declined enrollment for yourself and/or your Dependent(s), you and/or your Dependent(s) may qualify for Special Enrollment under the following two conditions:

Condition 1: **Loss of Other Coverage**

- you and/or your Dependent(s) were covered under another group health plan or had other health insurance coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; **and**
- the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment, or reduction in work hours), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation).

"Loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage). "Employer contributions" include contributions by any current or former employer (of the individual or another person) that is contributing to the coverage of the individual.

Request for enrollment under this condition must be made within **31 days** after termination of other health coverage.

Condition 2: **Newly Acquired Dependent(s)**

You are already enrolled under your employer's health plan (or are eligible to be enrolled but have not enrolled during a previous enrollment period), and a person becomes your Dependent through marriage, birth, adoption, or placement for adoption.

Request for enrollment under this condition must be made within **31 days** after the later of:

- the date of the marriage, birth, adoption or placement for adoption; or
- the date Dependent health coverage is available to you under the plan, provided you are enrolled (or eligible to be enrolled, but have not enrolled during a previous enrollment period).

(complete form on reverse side)

PART I - TO BE COMPLETED BY THE EMPLOYEE

Employee's full name	Employee's social security number:
Employee address	

1. I qualify for the following Special Enrollment Condition (Mark one box only):

A. ☐ **Loss of Other Coverage** - Complete the following if you have lost other health coverage. Attach the certificate of creditable coverage you have received from the prior plan/carrier. **Please note: we will be unable to process any changes until the certificate(s) of coverage is received.**

Date coverage ended_____________ Reason coverage ended____

B. ☐ **Newly Acquired Dependents** - Complete the following if you have acquired a new Dependent as described on the reverse side of this form.

Event ☐ **Marriage** ☐ **Birth of Child** ☐ **Adoption or Placement for Adoption** Date of the event_________________

Is your spouse presently covered under the Christian Brothers Employee Benefit Trust? ☐ **Yes** ☐ **No**

2. Please complete the following Member/Dependent information:

Are you currently covered under the group plan of your Employer? ☐ Yes ☐ No

I request to be covered under the Group Plan with the following coverages:

☐ Employee Only or ☐ Employee and Eligible Dependents (as defined in Your Employee Benefits Booklet)

☐ **Medical** ☐ **Dental** (if applicable) ☐ **Vision** (if applicable)

Note: Dependent coverage cannot be elected if you are not covered.

Please complete section below if selecting dependent coverage only **Must be completed entirely or can result in delay.**

List the name of each dependent and answer each question for each dependent.	Social Security Number	Birthdate MM/DD/YY	Sex M/F	Natural Child?	Full-Time Student?	Are You Legal Guardian?	Step-Child?	Handi-capped?	Resides in your home permanently?	
SPOUSE:				N/A	N/A	N/A	N/A	N/A	Yes	No
List Children Below										
1:										
2:										
3:										
4:										

Note: Dependents age 19 and over must meet eligibility requirements as defined in Your Employee Benefits Booklet. For stepchildren or any child for whom you have legal guardianship, a **DEPENDENT ELIGIBILITY FORM** must also be completed. Coverage does not take effect until after approved by **Christian Brothers Employee Benefit Services** in writing.

I represent that all statements and answers made above are true, complete, and correct. They will be part of my application for coverage. I agree that the coverage of anyone for whom such statements and answers are made will not be in force until approved by Christian Brothers Employee Benefit Services.

Employee's Signature	Date Signed

PART II - TO BE COMPLETED BY THE EMPLOYER

The employee whose signature appears above signed this form in my presence. To the best of my knowledge and belief, the statements and answers made above are true and complete.

Employer Signature	Title	Date Signed
Location Name		Location ID Number

Christian Brothers Employee Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679

PART III OTHER COVERAGE / AUTHORIZATION TO RELEASE INFORMATION

It is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.

☛ EMPLOYEE INFORMATION

Employee Name	Employee Soc. Sec. No.
Employee Address	

☛ OTHER COVERAGE

Please ✔ one of the following categories and provide the requested information if it applies.

❒ Single ❒ Widowed ❒ Divorced
❒ Married (Spouse's Name)____________ SSN:__________ Birth Date______
❒ Religious

Question			
Do you have any Additional Employers?	❒ YES	❒ NO	If yes, please provide name, address, and telephone number.
Do you or any dependent children have any Other Coverage (including AARP)?	❒ YES	❒ NO	If yes, please provide name, address, and telephone number.
Is Your Spouse Employed?	❒ YES	❒ NO	If yes, please provide name, address, and telephone number.
Spouse's Other Coverage (including AARP)?	❒ YES	❒ NO	If yes, please provide name, address, and telephone number.

ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.

I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS, AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.	➡ Signed (Employee) Date
AUTHORIZATION TO RELEASE INFORMATION: I authorize any physician, hospital, or other health care provider to release to **Christian Brothers Employee Benefit Trust**, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to receive a copy of this authorization.	➡ Signed (Employee) Date