

LATE ENTRANT/PRIOR WAIVER FORM

When to use this form: At the time you were first eligible to enroll, you waived coverage or did not complete your enrollment application within 31 days of eligibility or do not qualify as a special enrollment.

Please Note: Benefits will not be effective until the first of the month following a six month deferral period. The six month deferral period begins on the day we receive the form. Once enrolled, there will be a twelve month preexisting condition period (less prior creditable coverage if applicable) and deferred dental. You will receive a letter informing you of the effective date of coverage.

I. Employer Section *(Please print or type)*

Location Name:	Location ID #:		
Employee's Name: <i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	
Address: <i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

II. Employee Section

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)

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?	
									Yes	No
SPOUSE:				N/A	N/A	N/A	N/A	N/A		
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.

* Please submit proof of legal guardianship.

Signature of Employee:	Date:
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ENROLLMENT USE ONLY: Effective Date of Coverage:	Date Received:
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Letter Sent to: <input type="checkbox"/> Employer <input type="checkbox"/> Employee

Christian Brothers Employee Benefit Services

1205 Windham Parkway, Romeoville, IL 60446-1679



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As a new participant of the Christian Brothers Employee Benefit Trust, 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 check one of the following categories and provide the requested information if it applies.

Single Widowed Divorced

Married (Spouse's Name) _____ SSN: _____ Birth Date _____

Religious



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