Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability of Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

If you have a condition for which medical advice, diagnosis, care, or treatment was recommended or received within three months before your enrollment date and within three months after your effective date with the CBEBT, you will be subject to a pre-existing condition exclusion. A pre-existing condition exclusion period is the amount of time when payment for service related to that condition is limited. The exclusion period from the date of enrollment will be: 12 months for timely entrants (individuals who enroll when first eligible); or 6 months deferral period plus 12 months for late entrants (See Late Entrant/Prior Waiver Form). The pre-existing exclusion will not apply to (a) newborns or children under the age of 18 who are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption, or placement for adoption; or (b) pregnancy.

The pre-existing exclusion period may be reduced by the number of days you were covered under a prior health plan. You have the right to demonstrate coverage under a prior health plan. To do this, you may request a certificate of coverage from a prior health plan or insurer. When it is received, please forward a copy of this certificate to our office. Once the length of prior creditable coverage has been determined, you will receive a notice from us stating the length of your pre-existing condition exclusion period, if any.

SPECIAL ENROLLMENT RIGHTS

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage, birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

If enrollment is not made at the time these special enrollment opportunities occur, you may apply for coverage via a Late Entrant/Prior Waiver Form. 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 pre-existing condition period (less prior creditable coverage if applicable) and deferred dental.

Please contact your employer for any clarification regarding your enrollment in the CBEBT.

Revision Date 3/31/2006

Please read and fill out ALL applicable sections carefully.

I. EMPLOYER SECTION

☞ **Please print or type.**

Location Name ______________________ Location ID No. ______________

Employee's Name ______________________
Last Name First Name Middle Initial

Employee's Home Address ______________________
Street City State Zip Code

Employee's Soc. Sec. No. ____________ Date of Birth ____________ First Active Day of Work ____________

Occupation ____________ Annual Salary ____________

Enrollment Use Only
Effective Date of Coverage ____________

Phone# ____________ Email ____________

❐ Male ❐ Female ❐ Widowed ❐ Divorced ❐ Religious ❐ Single ❐ Married

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.

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/ Adopted 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:										
5:										
6:										

NOTE: Dependents age 19 and over must meet eligibility requirements as defined in Your Employee Benefits Booklet. For step-children or any child for whom you have legal guardianship, a *DEPENDENT ELIGIBILITY FORM* must also be completed. If you are required to complete the Dependent Eligibility Form, coverage will not take effect until after approved by **Christian Brothers Employee Benefit Services** in writing.
* Please submit proof of legal guardianship.

Signature of Employee: ______________________ **Date:** ____________

III. WAIVER OF GROUP COVERAGE

I hereby certify that I have been given an opportunity to apply for group coverage. *I understand that if I waive coverage at this time, future coverage may be delayed.* I decline to enroll:

❐ Myself ❐ My Dependents for coverage(s) because: ❐ Enrolled in Spouse's Plan ❐ Individual Policy ❐ Medicare ❐ Medicaid ❐ Enrolled with another employer plan ❐ Other (please explain) ____________

Effective Date ____________ Signature of Employee ______________________ Date ____________

IV. Life Insurance

☞**PLEASE NOTE: DO NOT USE THIS FORM TO CHANGE THE BENEFICIARY DESIGNATION.**

Employer Name ______________________ Location ID No. ______________

Employee Name (Last) ______________ (First) ______________ (Middle) ______________

Social Security No. ______________

Beneficiary (Give full name and relationship to member insured) ______________

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the member.

Signature of Employee ______________________ Date ______________

POPULAR BENEFICIARY DESIGNATIONS (see reverse side of this page)

Popular Beneficiary Designations

Be sure to use given names such as "Mary M. Doe", not Mrs. John Doe." The following sample designations may be helpful to you.

Type of Beneficiary	Standard Wording
1. insured's estate	my estate
2. one beneficiary	Anna L. Doe, wife
3. two beneficiaries	John A. Doe, father and Mary I. Doe, mother, equally or to the survivor
4. three or more beneficiaries	John A. Doe, father and Mary I. Doe, mother, and Henry J. Doe, son, equally or to the survivors or survivor
5. one beneficiary and two or more contingent beneficiary	Anna L. Doe, wife, if living, otherwise, Henry J. Doe, son
6. one beneficiary and two or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise, Henry J. Doe, son, Alice G. Doe, daughter, equally or to the survivor
7. one beneficiary and three or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise, Henry J. Doe, Alice G. Doe, Charles B. Doe, children, equally or to the survivor or survivors
8. two beneficiaries and one contingent beneficiary	John A. Doe, father, and Mary I. Doe, mother, equally or to the survivor; otherwise, Anna L. Doe, wife
9. two beneficiaries in unequal portions	three-quarters (3/4) of the proceeds to John A. Doe, father, if living, and one-quarter (1/4) to Anna L. Doe, mother, if living, the share of a deceased beneficiary to be paid to the survivor, if any.
10. trust with individual trustees	Richard Doe and John Smith, trustees, or a successor in trust under (trust name) established (date of trust agreement)
11. present or living trust	ABC Bank and Trust Company, Des Moines, Iowa, trustee or successor in trust under (trust name) established (date of trust agreement), provided however that the company had received with 180 days of the death of the insured, evidence satisfactory to the existence of such trust; otherwise to the state of the insured.
12. testamentary trust	Trustee of the Mary I. Doe trust or successor in trust established by the last will and testament of the insured dated ____________
13. minor beneficiaries	When either the primary or contingent designation includes one or more minor children, you need to complete an additional form, beneficiary designation with UTMA custodian. Please contact CBEBS for this form.

Note: **Do not complete this section if you are waiving group coverage.**

V. OTHER COVERAGE/ AUTHORIZATION TO RELEASE INFORMATION

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

	Location No.
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

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

Christian Brothers Employee Benefit Trust History

The ***Christian Brothers Employee Benefit Trust (CBEBT)*** was established on January 1, 1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The ***CBEBT*** has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The ***CBEBT*** is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with ***Christian Brothers Services*** to act as the Plan Administrator for the Trust. ***Employee Benefit Services*** is the division of ***Christian Brothers Services*** that administers all the benefits plans funded by the Trust.

Christian Brothers Services Mission Statement

The Mission of ***Christian Brothers Services*** is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

Important Phone Numbers

Customer Service/Benefit Information 800-807-0400

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