Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax
HealthEnrollment@CBServices.org

Do not use this form for new employees. This form must be completed and signed by the employee within the 60 days before the open enrollment effective date.

Effective Date ______

Open Enrollment Form

Employee Information

Location Name ______ Location Number ______ Name (Last, First, Middle Initial) ______

Home Street Address ______ City ______ State ______ Zip Code ______

Social Security Number ______ Date of Birth ______ Email Address ______ Home/Cell Phone ______

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Benefit Election(s) or Waiver of Medical Coverage

During this open enrollment period, I request to enroll myself and any applicable dependents below to the benefits my employer offers and following the group's "tiered" structure with the type of coverage as chosen here.

Who is to be Covered	Type of Coverage	Medical Election Plan
☐ Employee	☐ Medical ☐ Dental ☐ Vision	
☐ Spouse	☐ Medical ☐ Dental ☐ Vision	
☐ Child(ren)	☐ Medical ☐ Dental ☐ Vision	

Spouse and Child(ren) cannot be enrolled in coverage(s) not selected by the employee, and Dependent coverage(s) must match.

Dependent Information

Spouse's Name (Last, First, Middle Initial) ______ Social Security Number ______ Date of Birth ______ ☐ Male ☐ Female

Dependent's Name(s) (Last, First, Middle Initial)	Social Security Number	Date of Birth	Sex	Are You the Legal Guardian	Step-Child	Disabled Dependent
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Waiver of Medical Coverage

I hereby certify that I have been given an opportunity to apply for medical coverage. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event/special enrollment opportunity or during the next open enrollment period. ***I decline coverage for:*** ☐ Myself ☐ Spouse ☐ Dependent Child(ren) ☐ Myself and all Dependents

Declined Because: ☐ Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid ☐ Enrolled with another employer plan

☐ Other, Please Explain ______________________________

Signature of Employee ______ Date ______

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Other Coverage/ Authorization To Release Information

As a new member 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 Name (Last, First, Middle Initial)

Social Security Number

Home Street Address

City

State

Zip Code

Other Coverage Information

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

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Spouse's Name (Last, First, Middle Initial)

Spouse's Date of Birth

Spouse's Social Security Number

Do you have any additional Employers? ☐ Yes ☐ No

If yes, please provide employer name, address and telephone number.

Do you have any other coverages (including AARP)? ☐ Yes ☐ No

If yes, please provide employer name, address and telephone number.

Do your dependent children (if any) have any other coverages (including AARP)? ☐ Yes ☐ No

If yes, please provide employer name, address and telephone number.

(Please attach additional information if other coverage is not applicable for all dependent children)

Is your spouse employed? ☐ Yes ☐ No

If yes, please provide employer name, address and telephone number.

Spouse's other coverage (including AARP)? ☐ Yes ☐ No

If yes, please provide employer 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.

Employee Signature

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.

Employee Signature

Date