CHRISTIAN BROTHERS SERVICES

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

Open Enrollment Form

Effective Date:

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.

1. Employee Information

* Location Name:		* Location#:	
* Last Name:		* First Name:	
* Home Address:			
* City:		* State:	* Zip Code:
* Social Security #:		* Date of Birth:	
* E-mail Address:		* Home/Cell Phone:	

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

2. 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 Plan Election
☐ 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

List the name of each dependent and answer each question for each dependent	Social Security Number	Birthdate MM/DD/YY	Sex M/F	Are you Legal Guardian	Step-Child	Disabled Dependent
Spouse:				N/A	N/A	N/A
List Children Below						

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

because:

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

☐ Other; please explain:

Signature of Employee:		Date:	

3. 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 Name:	
Social Security Number:	
Address:	

Other Coverage Information

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

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Spouse's Name:			
Spouse's Date of Birth:		Spouse's Social Security #:	

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 carrier name, address and telephone number. _____ _____ _____
Do your dependent children (if any) have any other coverages (including AARP)?	☐ Yes ☐ No	If yes, please provide carrier 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 carrier 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.	Signature (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.	Signature (Employee): Date: