CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Group Coverage/Enrollment Form

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

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)

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program **(CHIP)** due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

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

Please read and fill out ALL applicable sections carefully.

1. Employer Section

Please print or type.

Location Name:		Location#:	
First Active Day of Work:		**Enrollment Use Only:** Effective Date of Coverage:	
Annual Salary:		Occupation:	

2. Employee Section

Employee's Last Name:		Employee's First Name:	
Employee's Home Address:			
City:		State:	Zip Code:
Employee's Soc. Sec. #:		Date of Birth:	
Email Address:		Home Phone:	

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

I request to be covered for the applicable benefits of my Group Plan as:

☐ Employee Only **or**
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee, Spouse and Child(ren)

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 F/M	Are you legal Guardian	Step-child
Spouse:				**N/A**	**N/A**
List Children Below					
1.					
2.					
3.					
4.					
5.					
6.					

Signature of Employee:		Date:	

3. 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 on Spouse's Plan ☐Individual Policy ☐Medicare ☐Medicaid
☐Enrolled with another employer plan ☐Other (please explain_____

Effective Date:		Signature of Employee:		Date:	

4. Life Insurance

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

Employer Name:		Location #:	
Employee Name:			
Social Security #:			

Primary Beneficiary Designation
(If additional Beneficiaries, please attach additional page)

Full Name (Last, First, MI)	Relationship	Date of Birth	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated.
In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

Contingent Beneficiary Designation
(If additional Beneficiaries, please attach additional page)

Full Name (Last, First, MI)	Relationship	Date of Birth	Share %

Payment will be made in equal share or all to the survivor unless otherwise indicated.
If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Policy.

Signature of Employee:		Date:	

POPULAR BENEFICIARY DESIGNATIONS (SEE NEXT 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 survivor(s)
5. one beneficiary and one 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 and Charles B. Doe, children, equally or to the survivor(s)
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 of the proceeds to John A. Doe, father, if living, and one-quarter 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 has received within 180 days of the death of the insured, evidence satisfactory to the existence of such trust; otherwise to the estate of the insured.
12. testamentary trust	Trustee of the Mary L. Doe trust or successor in trust established by the last will and testament of the insured dated……..

5. 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:		Location #:	
Employee SSN:			
Employee Address:			

Other Coverage Information

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

☐ Single ☐ Widowed ☐ Divorced ☐ Religious

☐ Married(Spouse's Name):		Birth Date:	
Social Security #:			

Do you have any additional Employers?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Do you have any other coverage (including AARP)?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Do your dependent children (if any) 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 received 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. ***Health 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 Health Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679