BLUE CROSS BLUE SHIELD OF SC

ENROLLMENT FORM August 2016 – August 2017

Reason for Application (please circle or underline): New Employee Open Enrollment Qualifying Event (Date)

Effective Date Requested	Date of Hire	Date of Birth	Gender
Employee: Last Name	First	Initial	Social Security Number
Address:			Group Number 71-53889-_____
Name of Employer General Synod, ARP Church Place of Employment: _____		Coverage Type Employee-Only Employee + One Dependent Family	Category Salaried Retiree Hourly COBRA
Phone:		E-Mail Address:	

MEMBERSHIP AND COVERAGE INFORMATION

Last Name First Initial	Gender	Birth Date	Social Security Number
Spouse:			
Child:			
Child:			
Child:			
Child:			
Child:			
Child:			

OTHER INSURANCE INFORMATION

Are you covered by the Federal Employees' Program (FEP) or Medicare?

If yes: MEDICARE A Effective Date _____ MEDICARE B Effective Date _____

Are you or your dependents listed above covered by another group medical insurance policy?

If yes: Insured's Name _____ Effective Date _____
Insured's Employer _____
Insurance Company _____ Policy Number _____

Names of Covered Dependents _____ _____
_____ _____
_____ _____
_____ _____

Employee Certification: I have read and understand every part of this enrollment application. I certify all information, herein, is accurate to the best of my knowledge.

Signature _____ Date _____

MERITAIN – dental

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COMPANY NAME: General Synod of the A.R.P. **GROUP #:** 823

THIS FORM TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS

CITY	STATE	ZIP

HOME PHONE NUMBER	WORK PHONE NUMBER

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? YES NO (i.e. Medicare, Tricare, spouse's plan)

IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____

TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____

IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____ ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. #/ CLOCK #

ANNUAL SALARY: $

☐ HOURLY ☐ SALARY

☐ NEW ENROLLMENT
- ☐ Active ☐ Retiree
- ☐ Full Time ☐ Part Time
- ☐ COBRA

☐ ENROLLMENT CHANGE
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Reinstatement ☐ Loss of Coverage
- ☐ Other: _____

Employer Representative Signature: _____

Date: _____

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	PPO (IF APPLICABLE)	COVERAGE LEVEL
DENTAL			EMPLOYEE ONLY EMPLOYEE + SPOUSE EMPLOYEE + CHILDREN FAMILY DECLINE

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:
a. The employee or eligible dependent loses their eligibly status to participant in Medicaid or CHIP, or
b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP* (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE	DISABLED DEPENDENT**
					DENTAL	YES NO
					DENTAL	YES NO
					DENTAL	YES NO
					DENTAL	YES NO
					DENTAL	YES NO

*IF ENROLLING STEPCHILDREN, DO THEY RESIDE WITH EMPLOYEE? YES NO
**IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

FULL TIME STUDENT INFORMATION (DEPENDENTS OVER AGE 19)

DEPENDENT NAME	NAME OF COLLEGE	COLLEGE PHONE NUMBER	SEMESTER	NUMBER OF CREDIT HOURS	DO YOU PROVIDE THE MAJORITY OF SUPPORT FOR DEPENDENT?
					YES NO
					YES NO

Starting the first day of the first plan year after October 9, 2009, for any covered dependent child who is enrolled in a post-secondary educational institution as condition of enrollment in the plan, who needs to take a medically necessary leave of absence (or reduce their student hours) due to their own serious illness or injury, coverage will be extended for that dependent child upon written certification by their treating physician that states the dependent is suffering from a serious illness or injury and that a leave of absence (or reduction in student hours) is medically necessary. If written certification is not received from the treating physician containing the above information, the plan will not provide the continued coverage. Coverage will be continued under the health plan until the earlier of (1) one year after the first day of the medically necessary leave of absence; (2) the date the dependent is no longer suffering from a serious illness or injury or (3) the date on which the coverage under the plan would otherwise terminate. ***In order for this extension to be fully granted, please refer to your Plan Document for more details regarding the extension.***

MERITAIN – dental

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COMPANY NAME: General Synod of the A.R.P.

CREDITABLE COVERAGE

HAVE YOU BEEN COVERED BY HEALTH INSURANCE IN THE PAST 63 DAYS? YES NO
HAVE ANY OF YOUR DEPENDENTS BEEN COVERED BY HEALTH INSURANCE IN THE PAST 63 DAYS? YES NO

IF YES, PLEASE SUBMIT A COPY OF THE CERTIFICATE OF CREDITABLE COVERAGE FROM YOUR PREVIOUS EMPLOYER OR INSURANCE COMPANY. IF A ☐ CERTIFICATE OF CREDITABLE COVERAGE IS NOT AVAILABLE AT THE TIME OF APPLICATION, SUBMIT IT AS SOON AS IT IS AVAILABLE; WITHOUT THIS INFORMATION A PRE-EXISTING LIMITATION WILL BE IMPOSED, IF YOUR PLAN HAS A PRE-EXISTING LIMITATION PROVISION.

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

IS YOUR SPOUSE EMPLOYED? YES NO IF YES, FULL TIME PART TIME SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECITVE DATE THAT YOUR SPOUSE IS ENROLLED IN WITH HIS/HER EMPOYLER

TYPE OF OTHER COVERAGE	CARRIER NAME	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
MEDICAL				
PRESCRIPTION				
DENTAL				
VISION				

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? YES NO
IF YES, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
MEDICAL					
PRESCRIPTION					
DENTAL					
VISION					

*COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)

ARE YOUR SPOUSE AND/OR ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? YES NO IF YES, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IF MEDICARE COVERAGE DUE TO:
☐					☐ AGE ☐ DISABILITY ☐ ESRD
☐					☐ AGE ☐ DISABILITY ☐ ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you are declining to enroll yourself or an eligible dependent for health coverage because you have (or your dependent has) existing health coverage, your employer may require that you provide a written statement indicating that you are declining coverage because of the existing health coverage. If the employer requires such a statement and notifies you of that requirement, you will receive a separate form to complete and you must complete it to preserve your right to a future special enrollment situation following a loss of that existing coverage.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE

BLUE CROSS BLUE SHIELD OF SC

Medical waiver

Complete if you are NOT enrolling in the Medical plan.

Enrolled in other coverage (please circle or underline) Yes No

If not enrolled in other coverage, please indicate reason for waiving medical coverage:

Cost $ _____ my monthly cost (exclude employer contribution)

Other _____

If enrolled in other medical coverage, please indicate the type of coverage:

Spouse's Coverage Medicare Military/VA/Tricare Individual Coverage Healthcare Exchange

Policy Owner's Name _____

Social Security Number _____

Name of Insurance Co. _____

Policy No. _____

Spouse's Employer _____

EMPLOYEE CERTIFICATION I understand that the benefits for which I am eligible are those disclosed in the group contract between Blue Cross Blue Shield of South Carolina and General Synod of the Associate Reformed Presbyterian Church. I certify that all statements made herein are complete and true to the best of my knowledge.

I understand that my elections may not be changed at any time during the plan year unless a qualifying event occurs as defined by the Plan, or until the next open enrollment. The Benefits office or Human Resources department must be notified of qualifying events within 31 days.

Signature _____ Date _____

MERITAIN

Dental Waiver

Complete if you are NOT enrolling in the Dental plan.

Enrolled in other coverage (please circle or underline) Yes No

If not enrolled in other coverage, please indicate reason for waiving dental coverage:

_____

If enrolled in other dental coverage, please indicate the type of coverage:

Spouse's Coverage Individual Coverage

Policy Owner's Name _____

Social Security Number _____

Name of Insurance Co. _____

Policy No. _____

Spouse's Employer _____

EMPLOYEE CERTIFICATION I understand that the benefits for which I am eligible are those disclosed in the group contract between Meritain Health and General Synod of the Associate Reformed Presbyterian Church. I certify that all statements made herein are complete and true to the best of my knowledge.

Signature _____ Date _____