cbia health connections

Enrollment/Change Form For **non-medical** enrollment or changes only

Employer Name: _____ **Pending Paperwork Number** _____

Employer Group Number: _____ **Division Name:** _____

Contact your benefits administrator for eligibility and available options.

ENROLLMENT/CHANGE REASON

❑ Enroll ❑ Change ❑ Terminate ❑ Other Reason _____

EMPLOYEE INFORMATION

Employee Name	Date of Hire/Rehire/Retirement	Part- to Full-time Employment Date	Effective Date
Street Address Apt #	Email	Marital status ❑ Single ❑ Married	# of hours worked per week: _____ Are you: ❑ Actively at work ❑ COBRA ❑ Retired
City, State, ZIP	Home Telephone ( )	Work Telephone ( )	Do you or any dependents have Medicare? Part A ____ Part B ____ Both ____

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS AND INDICATE ELECTIONS AT RIGHT. (Note that dependent coverage ends at age 26.)

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	Medical	Dental	Vision	Critical Illness	Accident	Hospital Indemnity
Employee	❑ M ❑ F								
Spouse Includes civil unions and domestic partners*	❑ M ❑ F								
Child	❑ M ❑ F								
Child	❑ M ❑ F								
Child	❑ M ❑ F								
Child	❑ M ❑ F								

*A Domestic Partner Affidavit (if applicable) must be completed at the time of enrollment and retained by the employee. A copy must be provided to the employer. See cbia.com for a copy of the affidavit.

LIFE & DISABILITY

Group Basic Life

❑ Life
Amount $_____
If life amount is salary-based, enter your annual salary $_____

STD/LTD

❑ Elect STD ❑ Waive STD
❑ Elect LTD* ❑ Waive LTD
Annual salary $_____
* Not available to employees who work fewer than 30 hours per week

Voluntary Life (for groups with 10 or more eligible employees)

Employee

❑ Elect $_____ OR_____ x salary
If life amount is salary-based, enter your annual salary $_____
Amounts over $100,000 require a Personal Health Application.
❑ Waive

Dependent

❑ Spouse - Amount $_____ (Amounts over $50,000 require a Personal Health Application.)
❑ Child(ren)
❑ Both
❑ Waive

Supplemental Life (for groups with 3 to 9 eligible employees) ❑ Elect ❑ Waive
If electing Supplemental Life, complete a separate Supplemental Life Enrollment Form.

Beneficiary

This is the only record of your beneficiary designation. Please retain a copy and give a copy to your employer to submit at the time of request for death benefits.

_____
Beneficiary Name (Last, First, MI)

_____ _____
Relationship of Beneficiary Date

DENTAL (List all dependents you are enrolling on page 1)

Voluntary - Ameritas

❑ Passive PPO 100%/80%/0%–$750
❑ Passive PPO 100%/50%/50%–$750
❑ Active PPO 100%/80%/50%–$1,000
❑ Passive PPO 100%/80%/50%–$1,000
❑ Passive PPO 100%/80%/50%–$1,500 with ortho
❑ Waive

Group - Ameritas

❑ Active PPO 100%/100%/60% $700
❑ Passive PPO 100%/80%/50% $1,250
❑ Passive PPO 100%/80%/50% $1,250 w/ Ortho
❑ Passive PPO 100%/80%/0% $1,000
❑ Passive PPO 100%/80%/50% $1,000
❑ Passive PPO 100%/80%/50% $1,000 w/ Ortho
❑ Passive PPO 100%/80%/50% $1,500
❑ Passive PPO 100%/80%/50% $1,500 w/ Ortho
❑ Passive PPO 100%/80%/50% $2,000
❑ Passive PPO 100%/80%/50% $2,000 w/ Ortho
❑ Waive

VOLUNTARY ACCIDENT & ILLNESS BENEFITS. (Note that dependent coverage ends at age 26.)

Critical Illness Insurance

❑ Plan A ❑ Plan B ❑ Waive
Beneficiary_____
Relationship_____ Date_____

Accident Insurance

❑ Plan A ❑ Plan B ❑ Waive
Beneficiary_____
Relationship_____ Date_____

Hospital Indemnity Insurance

❑ Plan A ❑ Plan B ❑ Waive
Beneficiary_____
Relationship_____ Date_____

CONTINUED ON PAGE 2

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For non-medical only

Employee Name: _____

Employer Group Number: _____

VISION

☐ Elect ☐ Waive

IDENTITY THEFT

☐ Elect (employee email address required above) ☐ Waive

☐ Individual ☐ Gold

☐ Family ☐ Platinum

AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's and employer's signatures are required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

Employee Signature Date

Employer Signature Date