HC | CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

Contact your benefits administrator for eligibility and available options.

Voluntary Accident & Illness Benefits Enrollment Form

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

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

ENROLLMENT

❑ 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 DEPENDENTS ENROLLING FOR COVERAGE. (Note that dependent coverage ends at age 26.)

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	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					

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

Critical Illness Insurance

❑ Waive

❑ Plan A ❑ Plan B

Accident Insurance

❑ Waive

❑ Plan A ❑ Plan B

Beneficiary_____

Relationship_____ Date_____

Hospital Indemnity Insurance

❑ Waive

❑ Plan A ❑ Plan B

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.

If you're declining enrollment for yourself or your dependents (including your spouse) or, if you have a new dependent as a result of marriage, civil union, domestic partner, birth, adoption, or placement for adoption, you may enroll yourself and your dependents during your employer's open enrollment period.

Employee Signature _____ Date _____

Employer Signature _____ Date _____

ENROLLMENT INSTRUCTIONS

- Check with your employer for available benefit options.
- Complete all items to avoid delays in processing.
- Please complete all sections including date of birth and Social Security Number
- Your signature and date and your employer's signature and date must be on the form.
- Covered dependents are eligible to age 26.
- An affidavit may be required at time of claim to verify domestic partner relationship. See cbia.com for a copy of the affidavit.