



# Enrollment/Change Form October 2024 and beyond

Employer Name: \_\_\_\_\_ Pending Paperwork Number \_\_\_\_\_

Employer Group Number: \_\_\_\_\_ Division Name: \_\_\_\_\_

For companies with 10+ employees

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 <input type="checkbox"/> Single <input type="checkbox"/> Married	# of hours worked per week: _____ Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> COBRA <input type="checkbox"/> 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	<input type="checkbox"/> M <input type="checkbox"/> F								
Spouse <small>Includes civil unions and domestic partners*</small>	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> 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.

## MEDICAL

### HSA Plans

- HSA \$5,500 30%
- HSA \$4,750 30%
- HSA \$3,500 30%

### PPO Plans

- PPO \$35/\$50 \$4,000 30%
- PPO \$30/\$45 \$3,000 10%
- PPO \$30/\$45 \$1,500

Check if enrolling a disabled dependent age 26 or over and contact CBIA Service Corp. to obtain a form for submitting proof of disability.

## LIFE & DISABILITY

<b>Group Basic Life</b>		<b>Voluntary Life</b> (for groups with 10 or more eligible employees)	
<input type="checkbox"/> Life Amount \$ _____ If life amount is salary-based, enter your annual salary \$ _____		<b>Employee</b> <input type="checkbox"/> Elect \$ _____ OR _____ x salary If life amount is salary-based, enter your annual salary \$ _____ Amounts over \$100,000 require a Personal Health Application. <input type="checkbox"/> Waive	<b>Dependent</b> <input type="checkbox"/> Spouse - Amount \$ _____ (Amounts over \$50,000 require a Personal Health Application.) <input type="checkbox"/> Child(ren) <input type="checkbox"/> Both <input type="checkbox"/> Waive
<b>STD/LTD</b> <input type="checkbox"/> Elect STD <input type="checkbox"/> Waive STD <input type="checkbox"/> Elect LTD* <input type="checkbox"/> Waive LTD Annual salary \$ _____ <small>* Not available to employees who work fewer than 30 hours per week</small>		<b>Supplemental Life</b> (for groups with 3 to 9 eligible employees) <input type="checkbox"/> Elect <input type="checkbox"/> 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 \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employer Group Number: \_\_\_\_\_

For companies with 10+ employees

**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

**Accident Insurance**

- Plan A
- Plan B
- Waive

**Hospital Indemnity Insurance**

- Plan A
- Plan B
- Waive

Beneficiary \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

**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 \_\_\_\_\_