cbia health connections

# COBRA/State Continuation Enrollment/Change Form

**October 2024 and beyond**

*For companies with 10+ employees*
*Contact your benefits administrator for eligibility and available options.*

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

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

## 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 ☐ Retired ☐ COBRA |
|---|---|---|---|
| | | | |

| 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<br>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.**

## 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.**

## DENTAL (List all dependents you are enrolling in dedicated field above)

**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

## VISION

☐ Elect ☐ Waive

## 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 signature is 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** _____