MERITAIN HEALTH

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION
(Employer Representative – Unsigned or Incomplete forms will be returned and may delay enrollment)

(For Employer Use Only) – Retain a copy for your records.
Confirmation No._____

Employer Name	Group Number	Department Number	Date of Hire	Effective Date of Change
			/ /	/ /

Certified by (Authorized Representative)	Date	Employer Telephone
	/ /	( ) -

Employers please indicate which Health Plan options your districts offers:

☐ **Platinum** ☐ **Gold** ☐ **Silver** ☐ **Bronze** ☐ **All Plans**

Enter information at www.meritain.com or
Mail to: MERITAIN HEALTH
300 CORPORATE PARKWAY
AMHERST, NEW YORK 14226

ENROLLMENT CHANGE SECTION **Effective Date of Change**_____/_____/_____ **(indicate changes below)**

EMPLOYEE INFORMATION – COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)
Submit a copy of certificate of creditable coverage with this form. ☐ **Please check if no prior coverage.**

Employee Name: Last	First	MI	Sex	Date of Birth	Employee ID No. - **REQUIRED**
			☐ M ☐ F	/ /	- -

Will Employee be Medicare Eligible at age 65? ☐ Yes ☐ No

☐ **Employee Name** From: _____ To: _____

☐ **Employee Address** From: _____ To: _____

_____ _____

☐ **Employee Phone** From: _____ To: _____

☐ **Marital Status** From: ☐ Single ☐ Married ☐ Divorced To: ☐ Single ☐ Married ☐ Divorced

☐ Termination
Choose Reason

☐ Active ☐ Reduction In Hours ☐ Terminate Employment
☐ Lay Off ☐ Medicare Entitlement ☐ Leave of Absence
☐ Death ☐ Open Enrollment Period ☐ Divorce
☐ Retired ☐ Marriage
☐ Other _____

You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.

☐ Dependent Status
(When adding or terminating a dependent you must complete Dependent Section on the reverse side.)

☐ Add Dependent(s)
Reason for Addition:
☐ Newborn
☐ Adoption
☐ Newly Eligible Full-time Student
☐ Marriage
☐ Open Enrollment Period
☐ Other _____

☐ Terminate Dependent(s)
Reason for Termination:
☐ Ineligible Child
☐ Marriage
☐ Divorce
☐ Open Enrollment Period
☐ Death
☐ Other _____

EMPLOYEES: You must check one box in each column below:

Medical Plan
Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event. You may only change to a higher level of benefits with a 12 month notice to your employer.
EMPLOYERS: ATTACH A COPY OF 12 MONTH NOTICE TO CHANGE FORM.
TO: ☐ **Platinum** ☐ **Gold** ☐ **Silver** ☐ **Bronze**

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child or Children
☐ Family
☐ Terminate Medical
☐ No Change Medical

Voluntary Vision Plan
TO:

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Vision
☐ No Change Vision

Voluntary Dental Plan
Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.

TO: ☐ **High** ☐ **Low**

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Dental
☐ No Change Dental

Basic Life – All life insurance will automatically terminate upon employment termination or retirement.

☐ Add Basic Life
☐ Term Basic Life
☐ No Change

Optional Life – Changes in Optional Life coverage must be submitted using the Lincoln Financial Group Evidence of Insurability form unless you are terminating coverage.

EMPLOYEES: Check all boxes that apply:

☐ Terminate Optional Employee ☐ Terminate Optional Dependent
☐ Terminate Optional Spouse ☐ No Change Optional Life

DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent ID Number	Full-Time Student? (Y or N)	You must check one box in each line below for each dependent listed.
1.			/ /	- -		**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline
2.			/ /	- -		**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline
3.			/ /	- -		**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline
4.			/ /	- -		**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline

BASIC LIFE – CHANGE Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's ID No.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.
Street Address			City	State	Zip

OPTIONAL LIFE – CHANGE Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's ID No.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, vision, or dental plan? ☐ Yes ☐ No

If yes, type(s) of coverage: ☐ Medical ☐ Vision ☐ Dental

Name of individual with other coverage:

Name of insurance carrier or TPA:_____Group No._____

Address:_____

Name of employer providing coverage:

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No

Phone:_____

ADDITIONAL CHANGES – Please add any comments concerning your changes.

Please read, sign, and date the following Authorization & Acknowledgement

- I have read and understand the information provided in the summary of benefits and other enrollment materials.
- On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law.
- Are you declining any coverage due to coverage in another plan? ☐ Yes ☐ No
  If yes, is the other coverage COBRA? ☐ Yes ☐ No ☐ Other (Please Explain)_____

To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.

Employee's Signature	Date:

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE