

Christian Brothers

Employee Benefit Services

1205 Windham Parkway Romeoville IL 60446

Phone: 800-807-9460 Fax: 630-378-3005



OPEN ENROLLMENT FORM

OPEN ENROLLMENT
EFFECTIVE DATE:

07/01/2011

When to use this form: This form is only to be used when an open enrollment period has been granted by Christian Brothers Employee Benefit Services. Note, the employee must already be enrolled for Life and LTD benefits. **Do not use this form for new employees or employees already enrolled for medical/dental benefits.**

This form must be completed and signed by the employee before the effective date of the open enrollment. Once enrolled, there will be a twelve month preexisting exclusion period (less prior creditable coverage if applicable) and deferred dental provisions will apply. The preexisting exclusion period may be reduced by the number of days you were covered under a prior health plan. To do this, you may request a certificate coverage from a prior health plan or insurer. When it is received, please forward a copy of this certificate to our office. Once the length of your prior creditable coverage has been determined, you will receive a notice from us stating the length of your preexisting condition exclusion period, if any.

1. EMPLOYER SECTION (Please print or type)

Location Name:	Diocese of Shreveport			Location#:	
Employee's Name:					
Employee's Home Address		Street:			
City:		State:		Zip Code:	
Employee's Soc. Sec. #:			Date of Birth:		

2. EMPLOYEE SECTION FOR DENTAL COVERAGE

Under this open enrollment period, I am requesting to enroll:

Employee Only Dependents Only Employee and Dependents

Please Complete section below if selecting dependent coverage.

Must be completed entirely or can result in delay.

List the name of each dependent and answer each question for each dependent.	Social Security Number	Birthdate MM/DD/YY	Sex F/M	Natural/Adopted Child	Full-Time Student	Are you legal Guardian	Step child	Handi-capped	Resides in your home permanently
Spouse:				N/A	N/A	N/A	N/A	N/A	

List Children Below

1.									
2.									
3.									
4.									
5.									
6.									

NOTE: Dependents age 19 and over must meet Eligibility requirements as defined in Your Employee Benefits Booklet. For Step-Children or any child for whom you have legal guardianship, a *DEPENDENT ELIGIBILITY FORM* must also be completed. If you are required to complete the Dependent Eligibility Form, coverage will not take effect until after approved by **CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST** in writing.

*Please submit proof of legal guardianship.

Signature of Employee:		Date:	
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5. Other Coverage/ Authorization To Release Information

As a new participant of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.

Employee Name:		Location #:	
Employee SSN:			
Employee Address:			

Other Coverage Information

Please **x** one of the following categories and provide the requested information if it applies.

Single Widowed Divorced Religious

Married (Spouse's Name): _____ Birth Date: _____

Social Security #: _____

Do you have any additional Employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____
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Do you or any dependent children have any other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____
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Is your spouse employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____
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Spouse's other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____
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ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.

I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.	Signed (Employee) _____ Date _____
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AUTHORIZATION TO RELEASE INFORMATION: I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to received a copy of this authorization.	Signed (Employee) _____ Date _____
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