

Please return to Treasury Services



CLERGY/EMPLOYEE NAME AND ADDRESS:		ADDRESS CORRECTIONS:	

		Your phone number (mandatory): _____	
CURRENT COVERAGE:		NEW ELECTIONS: (MARK ELECTIONS BELOW)	
Employee ID:		Coverage Tier: <input type="checkbox"/> Single <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Children <input type="checkbox"/> Family	Plan: <input type="checkbox"/> Plan 6000 (former Basic) <input type="checkbox"/> Plan 4000 (former Basic Plus) <input type="checkbox"/> Plan 5500 HSA
Effective Date:			
Current Coverage:			

NAME	REL	GENDER	SSN	BIRTH DATE	EFFECTIVE DATE	HAS OTHER INSURANCE	DROP COVERAGE	
Information about you:							<input type="checkbox"/>	<input type="checkbox"/>
Your dependents:							<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	

*Dependent SSNs are required.

Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another health plan? YES NO

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee and will be subject to an eighteen (18) month waiting period before coverage can begin. In addition if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Release of Medical Information

By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility insurance company or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Healthgram, Inc., if requested.

The terms of the plan have been explained to me and I have a complete understanding of my rights and responsibilities under the Plan. I hereby authorize my employer to make payroll deductions for the premium required for participation in the Plan (s) or their authorized representatives I affirm that the information is correct.

EMPLOYEE SIGNATURE

DATE