



CHRISTIAN  
BROTHERS  
SERVICES

Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446  
800.807.9460 / 630.378.3005 fax

## SPECIAL ENROLLMENT FORM

### Applicability

Special Enrollment applies to you and/or your Dependent(s) if you/they are eligible for coverage under your employer's group health plan, and qualify under one of the Special Enrollment conditions described below. If you qualify under one of these conditions, please complete the form on the next page and submit to your employer within **31 days** of the Special Enrollment condition. We will review the information provided and notify your employer regarding the status of your coverage.

**Note:** Special Enrollment applies only to group health plan or other health insurance.

### Special Enrollment Conditions

If you previously declined enrollment for yourself and/or your Dependent(s), you and/or your Dependent(s) may qualify for Special Enrollment under the following three conditions:

#### Condition 1. Loss of Other Coverage

- You and/or your dependent(s) were covered under another group health plan or had other health insurance coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; **and**
- the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment, or reduction in work hours), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation).

"Loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage). "Employer contributions" include contributions by any current or former employer (of the individual or another person) that is contributing to the coverage of the individual.

Request for enrollment under this condition must be made within **31 days** after termination of other health coverage.

#### Condition 2. Newly Acquired Dependent(s)

You are already enrolled under your employer's health plan (or are eligible to be enrolled but have not enrolled during a previous enrollment period), and a person becomes your Dependent through marriage, birth, adoption, or placement for adoption.

Request for enrollment under this condition must be made within **31 days** after the later of:

- the date of the marriage, birth, adoption or placement for adoption; or
- the date Dependent health coverage is available to you under the plan, provided you are enrolled (or eligible to be enrolled, but have not enrolled during a previous enrollment period).

**Condition 3. Children's Health Insurance Program Reauthorization of 2009 (CHIP)** With the onset of the **(CHIP)** program two additional enrollment opportunities apply for you and/or your eligible dependents if either of the following occurs:

- Termination of Medicaid or **(CHIP)** due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

You and/or dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

**PART 1- TO BE COMPLETED BY THE EMPLOYEE**

Employee Name:		Social Security #:	
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Employee Address:	
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**1. I qualify for the following Special Enrollment Condition (Mark one box only):**

**A. Loss of Other Coverage-** Complete the following if you have lost other health coverage. Attach the certificate of creditable coverage you have received from the prior plan/carrier. **Please note: we will be unable to process any changes until the certificate(s) of coverage is received.**

Date Coverage ended \_\_\_\_\_ Reason coverage ended \_\_\_\_\_

**B. Newly Acquired Dependents-** Complete the following if you have acquired a new Dependent as described on the first page of this form.

Event:	<input type="checkbox"/> <b>Marriage</b> <input type="checkbox"/> <b>Birth of Child</b> <input type="checkbox"/> <b>Adoption or Placement for Adoption</b> Date of the event _____  Is your spouse presently covered under the Christian Brother Employee Benefit Trust? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
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**2. Please complete the following Member/Dependent information:**

Are you currently covered under the Group Plan of your Employer?  Yes  No

I request to be covered under the Group Plan with the following coverages:

Employee Only or  Employee and Eligible Dependents (as defined in Your Employee Benefits Booklet)  
 **Medical**  **Dental** (if applicable)  **Vision** (if applicable)

**Note:** Dependent coverage cannot be elected if you are not covered.

**Please complete section below if selecting dependent coverage only**

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	Are you legal Guardian	Step child	Handi-capped
<b>Spouse:</b>				<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>

**List Children Below**

1.	2.	3.	4.	5.	6.	7.	8.

NOTE: For Step-Children or any child for whom you have legal guardianship, a *DEPENDENT ELIGIBILITY FORM* must also be completed. Coverage will not take effect until after approved by **CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST** in writing.

I represent that all statements and answers made above are true, complete, and correct. They will be part of my application for coverage. I agree that the coverage of anyone for whom such statements and answers; are made will not be in force until approved by **CHRISTIAN BROTHERS EMPLOYEE BENEFIT SERVICES**.

Employee Signature:		Date:	
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Location Name:		Location #:	
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### 3. 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 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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Do your dependent children (if any) 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.**

<b>I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.</b>	Signed (Employee) _____ Date _____
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<b>AUTHORIZATION TO RELEASE INFORMATION:</b> 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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