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** do to request coverage under the group health plan.

To be Completed by Employee

Employee Name (Last, First, Middle Initial) | Social Security Number | Date of Birth

Home Street Address | City | State | Zip Code

Annual Salary | Occupation

I qualify for the following Special Enrollment Condition (Mark one box only)

☐ **Loss of Other Coverage** - Complete the following if you have lost other health coverage.

Date Coverage Ended | Reason Coverage Ended

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

☐ Marriage ☐ Birth of Child ☐ Adoption or Placement for Adoption Date of Event

Is your spouse presently covered under the Christian Brother Employee Benefit Trust? ☐ Yes ☐ No

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.

Dependent Information - Please complete section below if selecting dependent coverage only

Spouse's Name (Last, First, Middle Initial) | Social Security Number | Date of Birth | ☐ Male ☐ Female

Dependent's Name(s) (Last, First, Middle Initial)	Social Security Number	Date of Birth	Sex	Are You the Legal Guardian	Step-Child	Disabled Dependent
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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 HEALTH SOLUTIONS.

Employee Signature | Date | Location Name | Location

Employer Signature | Title