Group Plans Enrollment Form

Reset Form

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: Operation Mobilization Employer number: 74375

Employee name: Last: _____ First: _____ MI: _____

Birth date: ____/____/____ Social Security number: _____

Home address: _____

City: _____ State: _____ ZIP code: _____

Daytime telephone: (_____) _____ Email: _____

Sex: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single Employee classification: _____

Monthly salary: _____ Date of full-time employment: ____/____/____ Coverage effective date: ____/____/____

B. BENEFIT ELECTION

Term Life Insurance

Employee life (employer base) ☑ Yes ☐ No

Amount*: $ 20,000.00

Employee optional life insurance ☐ Yes ☐ No

GI amount***: $ _____

UW amount**: $ _____

Spouse life insurance (employer base $10,000) ☑ Yes ☐ No

Spouse optional life insurance** ☐ Yes ☐ No

Amount: $ _____

Child life insurance $10,000 ☐ Yes ☐ No

*If employer base life salary multiple is greater than four, *Evidence of Good Health Application* is required.
**Requires *Evidence of Good Health Application* in multiple of salary over $50,000 or a flat $100,000.
***Guaranteed Issue in flat amounts $10,000–$50,000 in $5,000 increments or multiple of salary up to $50,000.

AD&D (employer based $.20,000) ☑ Yes ☐ No

Disability Plans

Short-term Disability

☐ Economy Short Term Disability Plan ☑ Yes ☐ No

Long-term Disability

☐ Economy Long Term Disability Plan ☑ Yes ☐ No

If you are waiving Employer Paid Medical and/or Dental, please complete Waiver on other side.

Medical Benefits

For myself ☐ Yes ☐ No
For spouse ☐ Yes ☐ No
For eligible children ☐ Yes ☐ No

Coverage (check one):

☐ Global Core 5000[1]
☐ Health Choice 3000[1]

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.

Please complete and submit both this form and the *Medicare-coordinating Plans – Retiree Enrollment (Group Plans)* form if you are selecting a Medicare-coordinating plan. The coverage effective date depends on the date these forms are received.

Dental Plans

For myself ☐ Yes ☐ No
For spouse ☐ Yes ☐ No
For eligible children ☐ Yes ☐ No

Coverage (check one):

☐ Premier Dental Care Plan
☐ Choice Dental Care Plan
☐ Cigna Dental Care DHMO Plan

Continued on other side

GuideStone®

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Employee name: _____ Social Security number: _____

C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	MI	Social Security number	Relationship	Birth date	Sex M/F	Medical Yes/No	Dental Yes/No	ID number (Cigna Dental Care DHMO only)
			———	Self	———	—			

*Your spouse and children up to age 26 are eligible for coverage.

D. WAIVER OF MEDICAL AND/OR DENTAL COVERAGE

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical and/or dental coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

☐ Myself ☐ All eligible dependents
☐ Myself and all eligible dependents ☐ Only these dependents:

I waive dental coverage for:

☐ Myself ☐ All eligible dependents
☐ Myself and all eligible dependents ☐ Only these dependents:

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that waiting periods and other limitations may apply.

Special enrollees for medical coverage: Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

Note: Please see the plan booklets for information about waiting periods and other limitations for special enrollees.

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ **Date:** _____/_____/_____

Employer representative: _____ **Date:** _____/_____/_____

Email to: Your Group Plans Support Team **or** *Group.Insurance@GuideStone.org*

GuideStone®

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