EMPLOYER ANNUAL ELECTION FORM
GROUP PLANS

Complete this form and return to Insurance Plans by 10/24/2024 for changes that will be effective 01/01/2025.

RESET FORM

1. EMPLOYER INFORMATION

Employer name: _____

Employer number: _____ State: _____

Please indicate any changes to current continuation options in Section 7.

2. MEDICAL PLAN OPTIONS

1. Are you adding, deleting or changing any medical products? ☐ Yes ☐ No
2. Are you adding, deleting or changing any medical classes? ☐ Yes ☐ No
3. Are you adding, deleting or changing any medical contribution amounts/arrangements? ☐ Yes ☐ No
4. Are you making changes to the current continuation options for your employees? ☐ Yes ☐ No

If you selected "Yes" to question 1, 2 or 3, please fill out the information below.

Please limit your medical plan choices to no more than two plans. If you would like to discuss a need for multiple plan designs, please contact your Insurance Plans relationship manager.

IMPORTANT: Please fill out the sections below to reflect all plan options you will be offering in 2025, including new plans and plans not changing.

EMPLOYER CONTRIBUTION PERCENTAGE/AMOUNT			
Employee Class	**Plan**	**Employer Contribution for Employee**	**Employer Contribution for Dependent**

[1]These plans do not constitute "creditable coverage" for Massachusetts residents.

[2]This plan does not constitute "creditable coverage" for active members age 65 and older under Medicare Part D. Participants in this plan could incur late enrollment penalties from Medicare.

*These plans are closed to newly enrolling groups.

Notes:

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GuideStone®

Employer name: _____ Employer number: _____

3. MEDICARE-COORDINATING PLAN OPTIONS

1. Are you adding, deleting or changing any Medicare-coordinating plan products? ☐ Yes ☐ No
2. Are you adding, deleting or changing any Medicare-coordinating plan classes? ☐ Yes ☐ No
3. Are you adding, deleting or changing any Medicare-coordinating plan contribution amounts/arrangements? ☐ Yes ☐ No

If you selected "Yes" for any of these questions, please fill out the information below.

IMPORTANT: Please fill out the sections below to reflect all plan options you will be offering in 2025, including new plans and plans not changing.

EMPLOYER CONTRIBUTION PERCENTAGE/AMOUNT			
Employee Class	**Plan**	**Employer Contribution for Employee**	**Employer Contribution for Dependent**

[1]To maintain eligibility for the Senior or Senior Plus plan, the employer must contribute at least 50% of the plan cost for each employee or retiree who joins the Senior or Senior Plus plan effective 1/1/2009 or later.

4.DENTAL PLAN OPTIONS

1. Are you adding, deleting or changing any dental products? ☐ Yes ☐ No
2. Are you adding, deleting or changing any dental classes? ☐ Yes ☐ No
3. Are you adding, deleting or changing any dental contribution amounts/arrangements? ☐ Yes ☐ No
4. Are you making changes to the current continuation options for your employees? ☐ Yes ☐ No

If you selected "Yes" to questions 1, 2 or 3, please fill out the information below.

IMPORTANT: Please fill out the sections below to reflect all plan options you will be offering in 2025, including new plans and plans not changing.

EMPLOYER CONTRIBUTION PERCENTAGE/AMOUNT			
Employee Class	**Plan**	**Employer Contribution for Employee**	**Employer Contribution for Dependent**

Employer name: _____ Employer number: _____

5. VISION PLAN OPTIONS

1. Are you adding, deleting or changing any vision products? ☐ Yes ☐ No
2. Are you adding, deleting or changing any vision classes? ☐ Yes ☐ No
3. Are you adding, deleting or changing any vision contribution amounts/arrangements? ☐ Yes ☐ No
4. Are you making changes to the current continuation options for your employees? ☐ Yes ☐ No

If you selected "Yes" to questions 1, 2 or 3, please fill out the information below.

IMPORTANT: Please fill out the sections below to reflect all plan options you will be offering in 2025, including new plans and plans not changing.

EMPLOYER CONTRIBUTION PERCENTAGE/AMOUNT			
Employee Class	**Plan**	**Employer Contribution for Employee**	**Employer Contribution for Dependent**

6. ANCILLARY PRODUCTS

1. Are you adding, deleting or changing any non-medical,dental or vision products, classes or contribution amounts/arrangements?
   ☐ Yes* ☐ No

*If yes, please reach out to your Insurance Plans Relationship Manager to discuss changes to non-medical, dental, or vision products.

Employer name: _____ Employer number: _____

7. COMMENTS

8. ACKNOWLEDGEMENTS

Responsibilities Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996

By checking the box below, the employer or the employer's authorized representative agrees to protect the confidentiality of protected health information (PHI) that the employer receives from GuideStone® and from its employees and their dependents as required under HIPAA and other applicable laws, to not use or disclose PHI other than permitted or required by GuideStone or the law, and to not use or disclose PHI for employment-related actions and decisions. The employer also agrees to make available to its employees any required notices under the provisions of HIPAA and any other applicable laws.

☐

Terms and Conditions of the Employer Adoption Agreement

By checking the box below, the employer or the employer's authorized representative acknowledges that the employer has read and agreed to the terms and conditions of the *Employer Adoption Agreement* (Agreement).

☐

9. SIGNATURE

Log into GuideStone Employer Access® Program (EAP) to access all of your renewal information.

EAP.GuideStone.org

Employer's Authorized Representative signature: _____ Date: _____

Please scan and email to ***InsuranceRenewal@GuideStone.org***.

GUIDESTONE FINANCIAL RESOURCES USE ONLY

☐ Yes ☐ No Employer requested that Group Plans mass move all employees from their existing medical/dental plan to:

Insurance Plans approval: _____ Date: _____

GP processed by: _____ Date: _____