Employee Annual Change Request
Group Plans

Note: Complete and return this form to your employer to change your coverage option(s) to the plans listed below. Your employer will need to return this form to GuideStone®. The coverage available for your selection is contingent upon your employer's enrollment and participation in the plan. Please review the *Summary of Benefits and Coverage* for the medical plans offered by your employer.

Reset Form

EMPLOYEE INFORMATION (Please provide dependent information on the reverse side, if applicable.)

Employee first name: _____ MI: _____ Last name: _____ Effective date:

Employee address: _____ City: _____ State: _____ ZIP code: _____

Social Security number: _____ Email: _____

Telephone number: _____ Classification: _____ (e.g., ministerial, administrative)

Marital status: ☐ Married ☐ Single Date of full-time employment: _____/_____/_____

EMPLOYER INFORMATION

Employer name: Overseas Management

Employer address: _____ City: _____ State: _____ ZIP code: _____

Employer number: 74396 Email: _____

MEDICAL PLAN OPTIONS

Coverage option — Please check

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

Check one:

☐ Global Core 5000[1]
☐ Cigna Global Heatlh 2000 (Middle East Class only)

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

DENTAL PLAN OPTIONS

Coverage option — Please check

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

Check one:

Cigna Global Plus ☐

AUTHORIZED SIGNATURES

Employee signature: _____ Date: _____/_____/_____

Employer authorized representative signature: _____ Date: _____/_____/_____

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GuideStone®

LIST ALL DEPENDENTS TO BE COVERED FOR 2019

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

Applicant first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: Applicant

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Spouse first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: Spouse

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Dependent first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ______________________

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Dependent first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ______________________

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Dependent first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ______________________

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Dependent first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ______________________

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Dependent first name: ______________________ MI: ________ Last name: ______________________

Social Security number: ______________________ Birth date: ___/___/___

Gender: ☐ Male ☐ Female Relationship: ☐ Child ☐ Other: ______________________

☐ Medical ☐ Dental Dental ID number: __________ (Cigna Dental Care DHMO enrollees)

Make copies of this page and complete if more than five dependent children will be covered.