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: Operation Mobilization USA

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

Employer number: 74375 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] ☐
Health Choice 3000[1] ☐

[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:

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

AUTHORIZED SIGNATURES

Employee signature: _____ Date: _____/_____/_____

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

Continued on other side

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.