CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax
hbsenrollmenthelp@cbservices.org

OPEN ENROLLMENT FORM	EFFECTIVE DATE:	

Do not use this form for new employees.

This form must be completed and signed by the employee within the 60 days before the open enrollment effective date.

1. EMPLOYER SECTION (Please print or type)

Location Name:		Location#:	
Name:			
Address:			
City:		State:	Zip Code:
Social Security #:		Date of Birth:	
E-mail Address:		Phone #:	

2. EMPLOYEE SECTION

During this open enrollment period, I request to be covered for the *applicable benefits selected by my employer as:*

Who is covered:
- ☐ Employee
- ☐ Spouse
- ☐ Children

Types of coverages:
☐ Medical ☐ Dental ☐ Vision

****Spouse and Children can not be enrolled in coverage not selected by the employee****

Please Complete section below if selecting dependent coverage. **Must be completed entirely or can result in delay.**

List the name of each dependent being enrolled for coverage.	Social Security Number	Birthdate MM/DD/YY	Sex F/M	Are you legal Guardian?	Step-child?
Spouse:				**N/A**	**N/A**
List Children Below					
1.					
2.					
3.					
4.					

Signature of Employee:		Date:	

3. Waiver Of Group Coverage

I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:

☐ Myself ☐ My Dependents for Coverage(s) because:

☐ Enrolled on Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid
☐ Enrolled with another employer plan ☐ Other -- please explain: _____

Effective Date:		Signature of Employee:		Date:	

4. Other Coverage/ Authorization To Release Information

As a new participant of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.

Employee Name:	
Social Security Number:	
Address:	

Other Coverage Information

Please **x** one of the following categories and provide the requested information if it applies.

☐ Single ☐ Widowed ☐ Divorced ☐ Religious

☐ Married(Spouse's Name):		Birth Date:	
Social Security #:			

Do you have any additional Employers?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Do you have any other coverage (including AARP)?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Do your dependent children (if any) have any other coverage (including AARP)?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Is your spouse employed?	☐ Yes ☐ No	If yes, please provide name address and telephone number.
Spouse's other coverage (including AARP)?	☐ Yes ☐ No	If yes, please provide name address and telephone number.

ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.

I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.	Signed (Employee)	Date
AUTHORIZATION TO RELEASE INFORMATION: I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to received a copy of this authorization.	Signed (Employee)	Date