Christian Education HEALTH PLAN

CHRISTIAN EDUCATION HEALTH PLAN
2969 Prairie St SW Ste 102 | Grandville MI 49418 | USA
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EMPLOYEE ENROLMENT AND CHANGE FORM

Part 1: Employee Information

Last Name ______________________ First Name ______________________ Gender M F

Address ______________________ City ____________ Province _______ Postal Code ___________

School Name ______________________ Employee Job Title ______________________

Employee School Email Address ______________________ Employment Date (or eligibility date) __________ (mm/dd/yyyy)

Personal Email Address ______________________ Date of Birth __________ (mm/dd/yyyy)

Phone ______________________ Mobile Landline SIN # ______________________

Marital Status Single Married Spouse name: ______________________

Spouse Date of Birth: ______________________ (mm/dd/yyyy)

Part 2: Insurance Enrolment or Change Information

New enrolment / Re-enrolment

___ Change (and check applicable boxes below)

___ Change Coverage *Note: Changes to coverage can be made during open enrolment to be effective the next Sept 1, or mid-year within 30 days of a qualifying life event.*

Reason for mid-year change in coverage: ______________________ Date of life event: ____________

___ Change Name Former name: ______________________ New name: ______________________

___ Change Address ___ Add Dependent (See Part 4) ___ Delete Dependent (See Part 4) ___ Change Student Status (See Part 4)

___ Change Coordination of Benefits (See Part 5) ___ Change Life Insurance Beneficiary (See Part 6)

Part 3: Insurance Coverage Information

Full Benefits

Include:

Extended Health, Dental, and Basic Benefits

Extended Health and Dental (Flex Plan) - *required for all eligible employees, with exceptions noted below*.*

Choose one: Flex 1 / Flex 2 / Flex 3 / Flex 4 / Flex 5 / Waive. I have extended health and dental through my spouse's employer. / my own other employer.

Choose one: _ Single (employee only) / __ Family / __ No one (Waive)

**To be eligible for extended health/dental benefits, Provincial Health Coverage must be in place.*
**Extended health/dental may be waived if employee has health/dental through another employer or their spouse's employer.*
**All eligible employees will have Basic Benefits, whether they participate in or waive Full Benefits.*

Basic Benefits

Basic Life/AD&D (Employee only) - *required for all eligible employees.*

Disability: Short-term and Long-term (Employee only) - *required for all eligible employees.*

Dependent Life - *required if you have a spouse and/or dependent children.*
If single with no dependent children, benefit is waived.

(Continued on next page…)

Employee Last Name: ____ Employee First Name: ________________________________

Part 4: Dependent Information

___ Add Dependent ___ Delete Dependent(s) Effective Date (mm/dd/yyyy) __________________________

Reason: ____

	First Name	Last Name (if different)	Date of Birth or Adoption (mm/dd/yyyy)	Gender M	Gender F	Full-time Univ. Student Age 21-24	Disabled Child Age 25+
Spouse	________	________	________	__	__	__	__
Child	________	________	________	__	__	__	__
Child	________	________	________	__	__	__	__
Child	________	________	________	__	__	__	__
Child	________	________	________	__	__	__	__
Child	________	________	________	__	__	__	__

Part 5: Co-ordination of Benefits – Important for Paying Claims

A. My Spouse has coverage under his/her employer's plan: Health (Choose one) Single Family None

Dental (Choose one) _ Single __ Family None

If this is a change in coordination of benefits, please list the effective date of change: _________________________

B. My child(ren) attending college or university full-time have coverage under a student plan:

Child's name __________________________________ __ Health __ Dental

Child's name __________________________________ __ Health __ Dental

If this is a change in coordination of benefits, please list the effective date of change: _________________________

If your dependent children have coverage under a former spouse's plan, please attach a separate note with details about their coverage.

Part 6: Life Insurance Beneficiary

Beneficiary designation is for Death Benefits ONLY. You or your spouse may change the beneficiary at any time without the beneficiary's consent. If your beneficiary is a minor, please contact the Plan at 877.274.8796 ext. 230.

Applicant's Beneficiary: Last Name ________________________________ First Name _________________ Relationship __________________

Spouse's Beneficiary: Last Name ________________________________ First Name _________________ Relationship __________________

AUTHORIZATION *Must be completed to process.*

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan. By enroling in this Plan, I authorize Manulife Financial, its agents and service providers to collect, use, disclose and exchange information collected in this form to underwrite, administer and pay claims. I also authorize the Christian Education Health Plan and its agents and service providers and my employer to collect, use, disclose, and exchange the information collected in this form to manage, administer, and arrange for benefits for me and my spouse and/or dependents, as applicable and to make any necessary payroll deductions which may be required. I authorize the use of my Social Insurance Number for administrative purposes. I understand that Plan information will be sent electronically to the email listed on this form. I understand that I may request a paper version of any emailed Plan information by contacting the Employee Benefits Team. If my participation in this Plan and /or employment with a member school should end for any reason, this authorization will continue for the purposes of managing, administering, and arranging for benefits that may continue after my participation and/ or employment terminates. I declare that the information above is accurate and true. Inaccurate information may invalidate my claim and /or participation in the Plan.

Signature____**Date** ______________________

(Please print this form, then sign and date) mm/dd/yyyy

Employer Section:

Employee is Salaried Hourly Employee Hours/Week _____ Employee Hours/Plan Year _________ Employee FTE ________

Annual salary $ ________________________ Number of months: ________ Average monthly salary: _________________

School Number __________ School HCSA amount (if any) for eligible employees ____________

Submit form via email (recommended) to: laura.landstra@cebteam.org
Hard copy forms are not required.

- OR -

via postal service to: Christian Education Health Plan
2969 Prairie St SW Ste 102
Grandville MI 49418 USA