CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@cobbt.org • www.bbtinsurance.org

Welcome to
Brethren Medical Plan

To enroll yourself and your eligible dependents, follow the directions below for help in completing the **Employee Application** on pages 1 and 2.

If you are declining coverage, please complete and sign the **Waiver of Coverage** on page 3.

Thank you.

Directions for Completing the Brethren Medical Plan Employee Application

Please use black or blue pen only. Do not abbreviate. Complete all fields, answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please contact Brethren Insurance Services.**

1. **Enrollment Information.** Select the reason you are completing this form and check the appropriate box.
   - **Enrollment:**
     - **New Enrollment:** This is your first opportunity to enroll after becoming eligible.
     - **Special Enrollment:** You are enrolling within 31 days of a special enrollment event as specified in the federal HIPAA regulations (See special enrollment rights on the back of this page).
     - **Continuation:** This option is available to qualified individuals previously enrolled in Brethren Medical Plan. Available to terminated employees. Maximum duration is 18 months.
   - **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current policy — normally 60 days prior to the anniversary date of the program.
     - **New Member:** You are a newly hired employee who becomes eligible at open enrollment or a current employee who elects coverage for the first time.
     - **Plan Change:** You are changing your current coverage.
     - **Add Dependents:** You are adding spouse and/or children to your coverage.

   Enter your effective date, Social Security number, and hire date.
     - Your Social Security number is used for internal purposes only.

2. **Coverage Applied For.** Provide the information requested in Section 2. Select Employee, Employee + Spouse, Employee + Child(ren), or Family Coverage. Select one of the health plans as offered by your employer. If you are declining health coverage for yourself, your spouse or your children, please complete the Waiver of Coverage form attached to this application. Your signature is required if you are declining coverage.

3. **Family Coverage Information.** Answer every question if you have a spouse or any children applying for coverage.
   - **Spouse** — Enter complete information.
   - **Children** — Enter complete information.

   If necessary, use a separate piece of paper and attach it to this application.

4. **Other Insurance Information.** If you, your spouse, or any of your children are applying for coverage and have other insurance coverage, enter the requested information completely. This information will allow for the proper coordination of your benefits.

5. **If you or your dependents are covered by Medicare,** enter the HIC number, which is the Medicare claim number on the Medicare ID card. **Be sure to enter the start dates where they apply:** Medicare A, Medicare B, End Stage Renal Disease, Dialysis, and Disability. The ESRD start date is the day ESRD regular course of dialysis begins (or the date of kidney transplant in the case of total renal failure). The disability start date is the day you or your dependents are entitled to Medicare due to disability.

6. **Application for Coverage.** Please read, date and sign this section. Your signature is required if you are electing coverage.

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Special Notice to Employees
Brethren Medical Plan

Employee — keep this copy for your records.

Pre-existing condition waiting period
This plan does not include a pre-existing condition waiting period requirement.

Notice of special enrollment rights
If you or your dependents are eligible for coverage under the Brethren Medical Plan but choose not to enroll, you may have special rights to enroll at a later time without being considered a late enrollee, as outlined below.

Termination of employer contributions and loss of eligibility for other creditable coverage
If you and/or your dependents waive coverage under this plan because you are enrolled in other *creditable coverage*[1], you and/or your dependents may enroll in this plan later without being considered a late enrollee if employer contributions toward the other creditable coverage cease or if eligibility for the other creditable coverage is lost as a result of any of the following qualifying events:

- Termination of employment.
- Involuntary termination of the other health coverage.
- Reduction in the number of hours of employment.
- Change in marital status such as marriage, legal separation, divorce, or death.
- The other health coverage discontinues dependent coverage.

You or your dependents must enroll in this plan within the 31-day special enrollment period that immediately follows the day employer contributions cease or the other creditable coverage ends.

When new dependents become eligible for coverage
If you choose not to enroll in this plan, you may enroll later (without being considered a late enrollee) at the same time a new dependent becomes eligible to be covered under the plan because of marriage, birth, or adoption. You and the new dependent must enroll in this plan within the 31-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

In the same way, if your spouse chooses not to enroll in this plan, he or she may enroll later (without being considered a late enrollee) at the same time a newborn or newly adopted child becomes eligible to be covered under the plan. Your spouse and the new dependent must enroll in this plan within the 31-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

Special enrollment rights under Children's Health Insurance Program Reauthorization Act of 2009
If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in Medicaid or a state Children's Health Insurance Program, you and/or your dependents may enroll in this plan later without being considered a late enrollee if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible for coverage under this plan but choose not to enroll, you and/or your dependents may enroll in this plan later without being considered a late enrollee if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP that provides help in paying for coverage under this plan.

You and/or your dependents must enroll in this plan within the 60-day special enrollment period that immediately follows the date coverage under Medicaid or CHIP terminates or the date it is determined that you and/or your dependents are eligible for a state premium assistance subsidy, whichever applies.

Enrolling at any other time
Any eligible individual who does not enroll in this plan within his or her respective enrollment or special enrollment period will be considered a late enrollee. A late enrollee will only be eligible to enroll in the plan during the annual open enrollment period.

To request special enrollment
To request special enrollment or to obtain additional information, contact your participating employer.

[1] *Creditable coverage includes a group health plan; health insurance coverage, including individual coverage; Parts A or B of Title XVIII of the Social Security Act (Medicare); Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan under Chapter 89 of Title 5, United States Code; a public health plan established or maintained by a state, the U.S. government, or a foreign country; a health benefit plan under Section 5(e) of the Peace Corps Act (22 U. S. C.2504(e)); or Title XXI of the Social Security Act (State Children's Health Insurance Program).*

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Employee Application
Brethren Medical Plan

1. ENROLLMENT INFORMATION

Enrollment: ❑ New ❑ Continuation ❑ Special (if special, reason _____)

Annual Open Enrollment: ❑ New Member ❑ Plan Change ❑ Add Dependents

Hire Date_____ **Effective date:**_____
(The day you become eligible.)

Employer Name _____

Employee Last Name _____ **First Name** _____ **MI** ____

Home Mailing Address _____

City _____ **State** _____ **ZIP** _____ – _____

Date of Birth _____ **Social Security Number** _____ **Phone** _____

Gender ❑ Male ❑ Female **Email** _____
We will use your email address solely to communicate with you about Brethren Insurance Services.

Marital Status: ❑ Single ❑ Married

Employment Status: ❑ Active Employee ❑ Inactive Employee
❑ If Pre-65 Retiree, Retirement Date _____

Continuation — Maximum of 18 months. Available to terminated employees previously enrolled in Brethren Medical Plan.

Continuation Start Date _____ Projected End Date _____

Previously covered with group as:

❑ 1. Employee (Termination of employment, reduction in hours, other)
❑ 2. Spouse (Divorce from employee, death of employee, other)
❑ 3. Dependent (Reached age limit, married, no longer full-time student, other)
❑ 4. Spouse & Dependents (Divorce from employee, death of employee, other)

2. COVERAGE APPLIED FOR

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one: ❑ PPO1500 ❑ HDHP2500 ❑ PPO2500 ❑ HDHP6000

3. FAMILY COVERAGE INFORMATION

Complete for your spouse and all children to be covered.

Last Name (if different) _____ **First Name** _____ **MI** ____

Spouse Date of Birth _____ **Social Security Number** _____

Last Name (if different) _____ **First Name** _____ **MI** ____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

Continued...

Employee Name _____ **Employee SSN** _____

"Family Coverage Information" Continued...

Last Name (if different) _____ **First Name** _____ **MI** _____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

Last Name (if different) _____ **First Name** _____ **MI** _____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

If you and the other parent of the dependents listed above are divorced or separated, who has custody of the dependents? ❑ Employee ❑ Other Parent
Who has financial responsibility for health expenses? ❑ Employee ❑ Other Parent

4. OTHER INSURANCE INFORMATION

Complete ONLY if you or your dependents have other group insurance.

Do you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved? ❑ Y ❑ N
If yes, complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other **Policy Number** _____ ❑ Single ❑ Family

Name of Insured _____ **SSN** _____ **Date of Birth** _____

Employer Name _____

Insurance Company Name _____ **Telephone** _____

Address _____

City _____ **State** _____ **ZIP** _____

5. MEDICARE/ESRD COVERAGE INFORMATION

If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name _____ HIC # _____

Medicare A	**Medicare B**	**ESRD Dialysis**	**Disability**
Start Date _____	Start Date _____	Start Date _____	Start Date _____

Name _____ HIC # _____

Medicare A	**Medicare B**	**ESRD Dialysis**	**Disability**
Start Date _____	Start Date _____	Start Date _____	Start Date _____

6. APPLICATION FOR COVERAGE

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material, thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Brethren Medical Plan and Blue Cross Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Brethren Medical Plan's Notice of Privacy Practices is included in the Plan document, or from the Brethren Medical Plan Privacy Office.

_____ _____
Authorized Employer Signature Date

_____ _____
Employee Signature Date

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Waiver of Coverage
Brethren Medical Plan

Please complete this form if you are waiving coverage. If you are not declining coverage, please do not complete this form.

EMPLOYEE INFORMATION

Employer Name _____

Employee Last Name _____ **First Name** _____ **MI** ____

Home Mailing Address _____

City _____ **State** _____ **ZIP** _____ – _____

Hire Date_____ **Social Security Number**_____
(The day you become eligible.)

Phone _____ **Email** _____
We will use your email address solely to communicate with you about Brethren Insurance Services.

If you are declining health coverage for yourself, your spouse, or your children because of other coverage, you may in the future be able to enroll yourself, your spouse, and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and them, provided you request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption. ***I acknowledge that I, along with my spouse and/or children (if any), were provided an opportunity to enroll in the Brethren Medical Plan.***

❑ **I do not wish to enroll for health coverage.** I hereby elect not to enroll in the Brethren Medical Plan for the reason indicated below and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made available with the company.

Reason:
❑ Covered under spouse's employer-based health insurance plan (Please complete **Other Insurance Information** section below)
❑ Covered under a Medicare supplement plan
❑ Other (please explain) _____

Your signature is required below for any waiver of coverage.

OTHER INSURANCE INFORMATION

Complete ONLY if you have other group insurance.

If you or any of your family members have other group coverage, please complete the following section. Check all that apply.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other **Policy Number** _____ ❑ Single ❑ Family

Name of Insured _____ **SSN** _____ **Date of Birth** _____

Employer Name _____

Insurance Company Name _____ **Telephone** _____

Address _____

City _____ **State** _____ **ZIP** _____

_____ _____
Signature of Employee *Date*