



For Office Use Only:

Agr. I.D. # _____

HealthFlex Enrollment/Change Form

New hires and newly eligible participants must provide complete information on each eligible dependent. Enrolled participants making changes should provide only the information that has changed. If you wish your mail to go to a different address, please see Part 8.

Part 1 – Plan Sponsor Information

Participant name _____ Social Security # _____

Legal address _____ Home phone # _____

_____ Work phone # _____

Marital status: Single Married Divorced Widowed Effective date of marital status _____

Conference/Plan sponsor/Employer _____ Church/Employer # _____

Membership: Clergy Lay Date of hire _____

Appointment/Employment status _____ Effective date _____

Percentage of employment: Quarter time Half time Three quarter time Full time

Processing event code (please use codes listed in Part 7) _____ Event date _____

Part 2 – Dependent Information

- List yourself and all eligible dependents, including your spouse, even if coverage is being declined. If you are currently enrolled and are adding/deleting a dependent, list only that dependent's information.
- If a dependent child is age 19 or older, indicate whether he or she is a full-time student or disabled.
- Indicate whether you wish to cover yourself, your spouse and/or dependent children.
- If you are declining coverage on yourself or a dependent, indicate whether that person has other health coverage and sign Part 5. (See the letter in your enrollment packet for the description of other health coverage. Use the description of other employer-sponsored group health coverage if you are a retiree.)

Name	Social Security #	Birth date	Relationship	Gender	Student*		Disabled		Cover		Other Health Insurance	
					Yes	No	Yes	No	Yes	No	Yes	No
_____	_____	_____	self	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	spouse	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	child	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* For dependent child(ren) over age 18 (please see Part 9 for additional dependents).

Part 3 – Participant Signature

I attest that the above participant information is true to the best of my knowledge. In addition, I have received, read and I understand the HIPAA Notice of Special Enrollment Rights, the HIPAA Notice of Pre-existing Condition Exclusion and the HIPAA Notice of Privacy Practices, which are included in my New-hire Enrollment Kit.

Participant signature _____ Date _____

Part 4 – Program Sponsor Authorization of Enrollment/Change

Program sponsor signature _____ Date _____

Part 5 – Declination of Coverage

If you are declining to cover yourself and/or any eligible dependents, it is important you understand certain program rules. By declining coverage, you are declining coverage for the balance of the current program year, and all subsequent program years unless you enroll for such coverage during a subsequent annual election period for coverage commencing on the following January 1. Also, any persons for whom coverage is being declined will be subject to late entrant provisions under the programs, which include possible benefit limitations on pre-existing conditions. In certain circumstances, you may be able to enroll for coverage for yourself and/or eligible dependents prior to a subsequent annual election period. These circumstances include marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 and change of status rules under HealthFlex. If you understand the above and still wish to decline coverage for yourself and/or any eligible dependents, indicate whether those eligible persons for whom you are declining coverage currently have other health coverage in Part 2, and sign on the line immediately below.

Participant signature _____ Date _____

Part 6 – Retirees Only

No change in information from previous *HealthFlex Enrollment/Change* form. (For retirement HealthFlex benefit enrollment purposes only)

Part 7 – Event Codes

	Event	Event Name		Event	Event Name
New Enrollment	1	New hire	Death	33	Participant death
	2	Newly eligible		34	Retiree death
	5	Special enrollment/new dependent		37	Dependent death
	6	Special enrollment/divorce	Termination	31	Declines coverage/non-payment
	7	Special enrollment/spousal death		36	Participant losing eligibility
	8	Special enrollment/spouse loses other coverage	Others	10	New Retiree
Add Dependent for Covered Participant	3	New dependent		11	Divorced spouse/legal decree
	4	Spouse loses other coverage		21	Regaining eligibility/same plan year
Delete Dependent for Covered Participant	9	Divorce		30	Late enrollment/annual election
	14	Spouse gains other coverage		32	Retiree to active
	17	Dependent child ineligible		35	Continuation

Part 8 – Mailing Address

Mailing address _____

Part 9 – Additional Dependents

Name	Social Security #	Birth date	Relationship	Gender	Student*		Disabled		Cover		Other Health Insurance	
					Yes	No	Yes	No	Yes	No	Yes	No
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* For dependent child(ren) over age 18