



**For Office Use Only:**

Agr. I.D. # \_\_\_\_\_

Return Completed Form to the Kansas West Conference Office

Caring For Those Who Serve  
1901 Chestnut Avenue  
Glenview, Illinois 60025-1604  
1-800-851-2201  
www.gbophb.org

## 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 9.

### Part 1 – Plan Sponsor Information

Participant name \_\_\_\_\_ Email \_\_\_\_\_

Legal address \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_ Primary phone # \_\_\_\_\_

\_\_\_\_\_ Alternate phone # \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed Effective date of marital status \_\_\_\_\_

Conference/Plan sponsor/Employer(s) \_\_\_\_\_ Employer(s) # \_\_\_\_\_

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 8) \_\_\_\_\_ Event date \_\_\_\_\_

### Part 2 – Dependent Information

- List yourself and all eligible dependents, including your spouse, even if you are declining coverage. If you are currently enrolled and are adding/deleting a dependent, list only that dependent's information.
- 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 | Disabled                 |                          | Cover                    |                          | Other Health Coverage <sup>1</sup> |                          |
|-------|-------------------|------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|
|       |                   |            |              |        | 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"/> |
| _____ | _____             | _____      | spouse       | _____  | <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"/> |

<sup>1</sup> For retirees and dependents of retirees, "other health coverage" means other employer-sponsored group health coverage as described in the HealthFlex Rules Regarding Retired Participants.

### Part 3 – Participant Signature

I attest that the above participant information is true to the best of my knowledge. In addition, if I am an active participant, 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 \_\_\_\_\_

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### Part 4 – Plan Sponsor Authorization of Enrollment/Change

Plan sponsor signature \_\_\_\_\_ Date \_\_\_\_\_

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### Part 5 – Declination of Coverage

If you are declining to cover yourself or any eligible dependents, it is important you understand certain plan rules. By declining coverage, you are declining coverage for the balance of the current plan year, and all subsequent plan 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 plans, which include possible benefit limitations on pre-existing conditions. In certain circumstances, you may be able to enroll for coverage for yourself 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 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.

Once you are covered as a retired participant, you must maintain continuous coverage in the plan. If you terminate coverage for any reason, at any time while a retired participant, you will **permanently** lose eligibility to return to HealthFlex. Your spouse and dependents are subject to the same one-time election rule and other eligibility rules of your plan sponsor.

At the time of your retirement, you may postpone HealthFlex coverage for you and your eligible dependents if and only if you have other employer-sponsored group health coverage. If you wish to decline coverage for yourself or any eligible dependent, indicate whether the eligible persons for whom you are declining coverage currently have other employer-sponsored group health coverage in Part 2, and sign on the line immediately below.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

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### Part 6 – Retirees Only

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

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### Part 7 – Default Rules for Retirees

If you do not complete and return this form to your plan sponsor, you are deemed to have refused coverage in retirement and you forfeit your eligibility under the plan.

**Part 8 – Event Codes**

|  | Event | Event Name                                     |
|--|-------|--|
| New Enrollment                           | 1     | New hire                                       |
|  | 2     | Newly eligible                                 |
|  | 5     | Special enrollment/new dependent               |
|  | 6     | Special enrollment/divorce                     |
|  | 7     | Special enrollment/spousal death               |
|  | 8     | Special enrollment/spouse loses other coverage |
| Add Dependent for Covered Participant    | 3     | New dependent                                  |
|  | 4     | Spouse loses other coverage                    |
| Delete Dependent for Covered Participant | 9     | Divorce  |
|  | 14    | Spouse gains other coverage                    |
|  | 17    | Dependent child ineligible                     |

|             | Event | Event Name                           |
|-------------|-------|--------------------------------------|
| Death       | 33    | Participant death                    |
|             | 34    | Retiree death                        |
|             | 37    | Dependent death                      |
| Termination | 31    | Declines coverage/non-payment        |
|             | 36    | Participant losing eligibility       |
| Others      | 10    | New Retiree                          |
|             | 11    | Divorced spouse/legal decree         |
|             | 21    | Regaining eligibility/same plan year |
|             | 30    | Late enrollment/annual election      |
|             | 32    | Retiree to active                    |
|             | 35    | Continuation                         |

**Part 9 – Preferred Mailing Address**

Mailing address \_\_\_\_\_  
 \_\_\_\_\_

**Part 10 – Additional Dependents**

| Name  | Social Security # | Birth date | Relationship | Gender | Disabled                 |                          | Cover                    |                          | Other Health Coverage <sup>2</sup> |                          |
|-------|-------------------|------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|
|       |                   |            |              |        | 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"/> |
| _____ | _____             | _____      | spouse       | _____  | <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"/> |

<sup>2</sup> For retirees and dependents of retirees, “other health coverage” means other employer-sponsored group health coverage as described in the *HealthFlex Rules Regarding Retired Participants*.