Group Plans Enrollment Form

Reset Form

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Employer number: _____

Employee name: Last: _____ First: _____ MI: _____

Birth date:_____/_____/_____ Social Security number: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Daytime telephone: (_____) _____ Email: _____

Sex: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single Employee classification: _____

Monthly salary: _____ Date of full-time employment: _____/_____/_____ Coverage effective date: _____/_____/_____

B. BENEFIT ELECTION

Term life insurance

Employee life (employer base) ☐ Yes ☐ No

Amount*: $ _____

Employee optional life insurance** ☐ Yes ☐ No

Spouse life insurance (employer base) ☐ Yes ☐ No

Spouse optional life insurance** ☐ Yes ☐ No

Child life insurance ☐ Yes ☐ No

* If employer base life salary multiple is greater than four, *Evidence of Good Health Application* is required.

**Requires *Evidence of Good Health Application*

AD&D ☐ Yes ☐ No

Disability plans

Short-term disability ☐ Yes ☐ No

- ☐ Economy Short Term Disability Plan
- ☐ Choice Short Term Disability Plan
- ☐ Premier Short Term Disability Plan

Long-term disability ☐ Yes ☐ No

- ☐ Economy Long Term Disability Plan
- ☐ Choice Long Term Disability Plan
- ☐ Premier Long Term Disability Plan

Supplemental Accidental Death & Dismemberment

For myself ☐ Yes ☐ No

Amount: $ _____

For my spouse ☐ Yes ☐ No

Amount: $ _____ (50% of employee volume)

Medical benefits

For myself ☐ Yes ☐ No

For spouse ☐ Yes ☐ No

For eligible children ☐ Yes ☐ No

Coverage (check one):

- ☐ Health Legacy 200
- ☐ Health Today
- ☐ Health Choice 500
- ☐ Health Choice 1000
- ☐ Health Choice 1500
- ☐ Health Choice 2000
- ☐ Health Choice 2500[1]
- ☐ Health Choice 3000[1]
- ☐ Health Choice 3000 80/20[1]
- ☐ Health Choice 4000[1]
- ☐ Health Choice 5000[1]
- ☐ Health Choice 5000 80/20[1]
- ☐ Value Health 5000[1,2]
- ☐ Health Saver 1500
- ☐ Health Saver 2600[1]
- ☐ Health Saver 2800[1]
- ☐ Health Saver 3000[1]
- ☐ Health Saver 5000[1]

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.

[2]This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older. Participants in this plan could incur late enrollment penalties from Medicare.

Please complete and submit both this form and the *Medicare-Coordinating Plans – Retiree Enrollment (Group Plans)* form if you are selecting a Medicare-coordinating plan. The coverage effective date depends on the date these forms are received.

Dental plans

For myself ☐ Yes ☐ No

For spouse ☐ Yes ☐ No

For eligible children ☐ Yes ☐ No

Coverage (check one):

- ☐ Premier Dental Care
- ☐ Choice Dental Care
- ☐ Cigna Dental Care DHMO*

*Dental ID number required; please provide on page 2.

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GuideStone® Insurance Plans

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Employee name: _____ Social Security number: _____

C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	MI	Social Security number	Relationship	Birth date	Sex M/F	Medical Yes/No	Dental Yes/No	ID number (Cigna Dental Care DHMO only)
			———	Self	———	—			

* Your spouse and children up to age 26 are eligible for coverage.

D. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ **Date:** _____/_____/_____

Employer representative: _____ **Date:** _____/_____/_____