

Employee Enrollment for Health Coverage

Congregational Employee Plan for The Brethren in Christ Church Health Plan

THIS IS NOT AN APPLICATION FOR INSURANCE. It is an enrollment form for self-funded health coverage provided by your denomination. The Congregational Employee Plan does not include a pre-existing conditions waiting period requirement.

1. Employer _____
2. Employer location _____
city state
3. Employee _____
first middle last
4. Social Security number _____
5. First day of work _____
6. Number of hours worked per week _____

To waive coverage

Complete this section if you choose not to enroll in the Congregational Employee Plan for The Brethren in Christ Church because you are enrolled in other creditable health coverage.

7. I waive health coverage for
 myself my spouse my dependents
8. I (we) have other creditable health coverage through
 Part A or Part B of Title XVIII of the Social Security Act (Medicare)*
 a group health plan provided by my spouse's employer*

Name of plan

- other group health plan coverage (provided by an employer other than the plan provided by your church)*

Name of plan

- Chapter 55 of Title 10, United States Code (Champus and other military health programs)*
- a medical care program of the Indian Health Service or of a tribal organization*
- individual health insurance coverage
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid)*
- a state health benefits risk pool*
- a health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefit Program)*
- 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))*
- Title XXI of the Social Security Act (State Children's Health Insurance Program – S-CHIP)*

9. Are all family members who are waiving coverage on the same plan? yes no
If no, please explain.
- _____
- _____

Having waived coverage, I understand I have the opportunity to enroll myself or my dependents later if I (we) lose other creditable coverage due to certain qualifying events which are outlined in the attached notice. I further understand that I (we) must enroll in the plan within a 90-day special enrollment period which immediately follows a qualifying event. If I (we) do not enroll within the 90-day special enrollment period, I (we) will not be eligible to enroll in the plan.

Signature

Date

***Enrollment in this coverage is a valid waive when determining if your employer meets participation requirements.**

To enroll in coverage

Complete this section if you are enrolling in the Congregational Employee Plan for The Brethren in Christ Church

10. I request health coverage for
 myself my spouse my dependents

11. Employee's address _____
street

city state ZIP

12. Telephone number: Daytime (_____) _____
 Home (if different) (_____) _____

13. Birth date _____
month day year

14. Age _____

15. Sex M F

16. Marital status single married widowed
 separated divorced

17. Job title _____

18. Please give reason for initial enrollment.

- new hire as of _____(date)
- change in hours as of _____(date)
- loss of previous creditable coverage as of _____(date)
- marriage, birth or adoption of child as of _____(date)
- loss of Medicaid/CHIP eligibility as of _____(date)
- eligible for premium assistance subsidy under Medicaid or CHIP as of _____(date)

19. If you are adding family members to **an existing policy**, check the appropriate box and provide the dates requested.

- Adding spouse; reason
 loss of previous creditable coverage as of _____(date)
 marriage as of _____(date)
 birth or adoption of child as of _____(date)
- Adding new dependents
reason for adding them at this time _____
- loss of Medicaid/CHIP eligibility as of _____(date)
- eligible for premium assistance subsidy under Medicaid or CHIP as of _____(date)

Spouse and dependents (complete if to be covered)

20. Name <i>(first, middle, last)</i>	Social Security Number	Birth Date <i>(month, day, year)</i>	Sex
Spouse			
Dependent			
Dependent			
Dependent			

21. If you and the other parent of the dependents listed above are divorced or separated,
 a. who has custody of the dependents? _____
 b. who has financial responsibility for health expenses? _____

22. If you have listed any dependents above who are ages 19 to 25, they must be unmarried, full-time college students to qualify for coverage. Please list the following information.

Name of Dependent	Current Credit Hours	Name and Address of College

Other medical insurance

23. Will anyone named on this enrollment form continue to have health coverage with another insurer after this plan goes into effect? yes (give details below) no
24. Will this coverage replace an existing health insurance policy for anyone named on this enrollment form?
 yes (give details below) no

Persons Covered	Name of Other Health Insurance	Is This an Employer-Provided Policy?	To Be Replaced?	Date of Replacement
		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	

Employee authorization

I authorize all health care providers to release any necessary medical information to MMA and the claims administrator to certify medical treatment or process claims for myself, my spouse, or my dependents. I understand that MMA and the claims administrator will share this information with third parties only if necessary for precertification, managing claims, or processing claims. I am responsible to notify my employer of any changes in the above information.

Employee's signature

Date

This page left blank intentionally.

Notice of Special Enrollment Rights

Congregational Employee Plan for The Brethren in Christ Church Health Plan

MMA Insurance Company has prepared this notice on behalf of your health plan.

If you or your dependents are eligible for coverage under the Congregational Employee Plan (CEP) but choose not to enroll, you may have special rights to enroll at a later time as outlined below.

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 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 90-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 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 90-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 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 90-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 (CHIP), you and/or your dependents may enroll in this plan later 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 if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP which provides help in paying for coverage under this plan.

You and/or your dependents must enroll in this plan within the 90-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.

Failure to enroll as required

Any eligible individual who does not enroll in this plan within his or her respective 90-day enrollment or special enrollment period will not be eligible to enroll in the plan.

To request special enrollment

To request special enrollment or obtain additional information, contact your congregation.

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).*

Employee – keep this copy for your records.



MMA Insurance Company
Post Office Box 483
Goshen IN 46527

Toll-free: (800) 348-7468
Telephone: (574) 533-9511
www.mma-online.org

MMA[®]