

Benefit Assistance Corporation

PO Box 950, Hurricane, WV 25526
Phone (304)562-1913 * Fax (304)562-1916

ENROLLMENT / CHANGE / TERMINATION FORM

(Complete or check all that apply)

Group Name

Division

Effective Date of Coverage or Change

**WEST VIRGINIA ANNUAL CONFERENCE UNITED METHODIST
FAMILY MEDICAL AND DENTAL BENEFIT PLAN**

Reason

For Enrollment Open Enrollment Re-enrollment Change in Coverage Terminations Other
Completion:

M
P
L
O
Y
E
R

Changes:

Change Name

Change Address

Change Coverage

Loss / Acquisition of Spouse's Group Coverage

Other - Specify _____

Date of Above Event _____

Dependent Changes:

Add Dependents due to:

Marriage Birth Adoption

Step-child QMCSO Other _____

Drop Dependents due to:

Divorce Death Other _____

Date of Above Event _____

Cancel Coverage Due To:

Termination of Employment

Reduction of Hours / Layoff

Voluntary Termination of Coverage / Other Coverage

Death

Other - Specify _____

Date of Above Event _____

(Check one or explain)

Involuntary

Voluntary

Gross Misconduct

Authorized Employer Representative Signature

LEVEL OF BENEFITS APPLIED FOR

MEDICAL AND DENTAL

Employee

Family

MEDICAL ONLY

Employee

Family

DENTAL ONLY

Employee

Family

EMPLOYEE IDENTIFICATION

Last Name First Name Middle Initial Social Security Number Date of Birth (Month / Day / Year)

Address Telephone Date of Hire (Month / Day / Year)

City, State, Zip E-mail Address (Optional)

Gender: Male Female Marital Status: Single Married Widowed Divorced Employment Status: Active Retired COBRA

DEPENDENT INFORMATION

(Complete only if you have elected dependent coverage)

Plan reserves the right to request that legal documentation (Birth Certificate, Court Decree, Guardianship Papers, Federal Income Tax Return, Verification Regarding Eligibility for Other Coverage, etc.) be attached to this Application if relationship is Child, Adoption, Step-Child, QMCSO or Other. Adult children eligible for Other Employer-Sponsored Coverage, other than coverage offered through a parent, may not be eligible to participate in this plan.

Relationship - (Spouse, Child, Step-child, Adoption, Other)	Name			Gender M / F	Date of Birth			Social Security Number	Eligible for Other Employer Coverage? (Y/N)
	First	MI	Last		Month	Day	Year		
Spouse								- -	
								- -	
								- -	
								- -	

Other Coverage: If you, your spouse and/or children are already covered under another group plan, list participant name and name of health insurance provider below:

Prior Coverage: If you, your spouse and/or children have had group health coverage in the past 18 months prior to enrolling in this Plan, please provide a copy of the Certificate of Group Health Plan Coverage provided by the prior carrier.

WAIVER OF COVERAGE

(Complete only if you wish to decline coverage)

I hereby decline coverage: for Myself for My Dependent Spouse for My Dependent Children for the Following Person(s) _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, eligibility will be subject to any eligibility requirements, special enrollment, open enrollment, late enrollment and other terms and provisions as specified in the group Plan Document

EMPLOYEE ENROLLMENT / CHANGE AUTHORIZATION

I hereby apply for the coverage or changes to my existing coverage under the group benefit plan as indicated above. This application shall supercede any previous application as of the effective date indicated above.

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 have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by the Plan Administrator.

Date

Employee Signature