

# Covenant Administrators, LLC, a 90 Degrees Benefit Company

## Open Enrollment/New Enrollment/Change/Termination Request Form

<input type="checkbox"/> <b>Enrollment</b> (Check one box only)	<input type="checkbox"/> <b>Coverage Status Change</b>	<input type="checkbox"/> <b>Termination*</b>
<input type="checkbox"/> 1. New Employee <input type="checkbox"/> 2. Rehired or Reinstatement of Coverage <input type="checkbox"/> 3. Special Enrollment <input type="checkbox"/> 4. OPEN Enrollment  Effective Date _____ Rehire Date _____ <input type="checkbox"/> I hereby decline health coverage at my eligible date due to the following reason(s): _____  Signature _____	<input type="checkbox"/> 1. Add Dependent <input type="checkbox"/> 2. Drop Dependent <input type="checkbox"/> 3. Add New Coverage <input type="checkbox"/> 4. Cancel <input type="checkbox"/> 5. Other _____  Effective Date _____  Reason for Change: <input type="checkbox"/> birth/adoption <input type="checkbox"/> marriage <input type="checkbox"/> divorce <input type="checkbox"/> loss of other coverage	<input type="checkbox"/> 1. Cancel Dependent Coverage <input type="checkbox"/> 2. Terminating Employment <input type="checkbox"/> 3. Death <input type="checkbox"/> 4. COBRA Qualifying Event (See back of this form)  Effective Date _____  If the above change is a termination of employment, you may be eligible for continued coverage under COBRA. Please review the stipulations set forth in your Summary Plan Description.
* Employer must complete and sign COBRA ACTION FORM on back		

**A. TO BE COMPLETED BY EMPLOYER – Please complete EACH block in this section.**

1. Group No. <b>326</b>	2. Employer Name: Bulloch County Board of Commissioners	3. Location/Division <input type="checkbox"/> Management <input type="checkbox"/> All Others
4. Employee's Original Effective Date of Coverage		

**Employer:** I certify that all the information included on this form is up to date and correct to the best of my knowledge. If Covenant is your COBRA Administrator and either the employee or dependent is terminating, please complete the COBRA Notice Action Form (on the back of this form).

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**B. EMPLOYEE INFORMATION (PLEASE PRINT)**

1. Social Security #	2. Date of Birth	3. Sex	4. Phone
5. First Name	6. Last Name	7. Middle Initial	
8. Home Address (Street, City, State, Zip Code)			9. Hire Date

**Are you or any of your dependents covered by another group health plan or Medicare?**  Yes  No

If "Yes", please attach a copy of the front and back of your Insurance or Medicare Card and complete 10 – 16 below.

10. Name of Insured on other Plan		11. SSN#	
12. Date of Birth	13. Name of Employer	14. Name of Carrier	15. Telephone No. of Employer
16. Names of individuals covered by Plan listed above:			

MEDICAL COVERAGE	MEDICAL PLAN	DENTAL COVERAGE
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family	<input type="checkbox"/> Base Plan <input type="checkbox"/> Plus Plan	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family

**D. CHANGE or CANCEL COVERAGE – FROM: TO:**

Medical – Plus or Basic	Dental	Medical – Plus or Basic	Dental
<input type="checkbox"/> Employee <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family	<input type="checkbox"/> Employee <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family	<input type="checkbox"/> Employee <input type="checkbox"/> Employee Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Employee <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Cancel Coverage

Change Name From: \_\_\_\_\_ To: \_\_\_\_\_

**E. Dependents**

1. Name (First, Last)	2. Sex (M/F)	3. Birthdate (Mo/Day/Yr)	4. SSN - Required	5. Relationship (Spouse, Child, Etc.)

**F. EMPLOYEE SIGNATURE**

**Special Enrollment:** If an eligible Employee or Dependent declined health coverage at the time of initial eligibility (and stated in writing at the time that coverage was declined because of alternative health coverage), and subsequently loses coverage under the other health plan and makes application for coverage within 31 days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of the loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contribution toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premium for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within 31 days of the acquisition of the new Dependent. Coverage for a Special Enrollee (other than a newborn or newly adopted child) will be effective after the date the plan administrator receives the enrollment form if it is a plan that uses pre-tax salary reductions for employee premium contributions.

I hereby request all coverage for which I am or may become eligible under the group coverage's administered by Covenant Administrators, LLC. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**G. TO BE COMPLETED BY EMPLOYER**

(If **COBRA IS** required, please complete the following and return to Covenant Administrators no later than 30 days after termination):

**COBRA NOTICE ACTION FORM**

(Please Print or Type)

Employer: \_\_\_\_\_

Group No.: \_\_\_\_\_

Employee: \_\_\_\_\_

Social Security # \_\_\_\_\_ — \_\_\_\_\_ —

Qualifying Beneficiary if other than employee: \_\_\_\_\_

Social Security # \_\_\_\_\_ — \_\_\_\_\_ —

Current Address (Street, City, State, Zip Code): \_\_\_\_\_

Qualifying Event Date: \_\_\_\_\_

Effective Date current coverage terminates: (Mo/Day/Year) \_\_\_\_\_

**Qualifying Event: (Check One)**

Termination/Retirement other than gross misconduct  
(18 mo. COBRA period / 29 mo. For Social Security Disability)

Covered employee is entitled to Medicare  
(36 mo. COBRA period)

Death of Covered Employee  
(36 mo. COBRA period)

A dependent ceases to be a dependent as defined by the Employer's Group Plan (36 mo. COBRA period)

Reduction in hours, includes Medical or Personal Leave of Absence, Suspension or Activated Military Reserve  
(18 mo. COBRA period / 29 mo. For Social Security Disability)

Employer files for bankruptcy  
(Applies to retiree coverage only)

Divorce or legal separation: A copy of the Court Order page including the legal date of divorce of legal separation is required (36 mo. COBRA period)

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**H. TO BE COMPLETED BY EMPLOYER - COBRA (If COBRA is NOT required, please complete the following):**

(Check One)

Voluntarily dropping coverage

Retiring and entitled to Medicare with no spouse and/or dependents on current coverage, or spouse and/or dependents also entitled to Medicare

Voluntarily dropping all spouse and/or dependent coverage

Other (explain) \_\_\_\_\_

Other group insurance without pre-existing conditions

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I. FOR COVENANT ADMINISTRATORS USE ONLY:**

Location: \_\_\_\_\_

Date Received: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Benefit Codes: **M D P V**  
**M D P V**  
**M D P V**

Sex: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Effective Date \_\_\_\_\_

Date of Change: \_\_\_\_\_