Covenant Administrators, LLC, a 90 Degrees Benefit Company

Open Enrollment/New Enrollment/Change/Termination Request Form

☐ Enrollment (Check one box only)	☐ Coverage Status Change		☐ Termination*
☐ 1. New Employee ☐ 2. Rehired or Reinstatement of Coverage ☐ 3. Special Enrollment ☒ 4. OPEN Enrollment **Effective Date** _____ **Rehire Date** _____ ☒ I hereby decline health coverage at my eligible date due to the following reason(s): _____ _____ **Signature**	☐ 1. Add Dependent ☐ 2. Drop Dependent ☐ 3. Add New Coverage ☐ 4. Cancel ☐ 5. Other_____ **Effective Date**_____	Reason for Change: ☐ birth/adoption ☐ marriage ☐ divorce ☐ loss of other coverage	☐ 1. Cancel Dependent Coverage ☐ 2. Terminating Employment ☐ 3. Death ☐ 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. 326	2. Employer Name: Bulloch County Board of Commissioners	3. Location/Division ☐ Management ☐ 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**
☐ Employee Only ☐ Employee plus Spouse ☐ Employee plus Child or Children ☐ Family	☐ Base Plan ☐ Plus Plan	☐ Employee Only ☐ Employee plus Spouse ☐ Employee plus Child or Children ☐ Family

D. CHANGE or CANCEL COVERAGE – FROM:

Medical – Plus or Basic	**Dental**
☐ Employee	☐ Employee
☐ Employee plus Spouse	☐ Employee plus Spouse
☐ Employee plus Child or Children	☐ Employee plus Child or Children
☐ Family	☐ Family

TO:

Medical – Plus or Basic	**Dental**
☐ Employee	☐ Employee
☐ Employee Spouse	☐ Employee plus Spouse
☐ Employee plus Child or Children	☐ Employee plus Child or Children
☐ Family	☐ Family
☐ Cancel Coverage	☐ 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.)