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** 07/01/2022 **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.)

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)
- ☐ Death of Covered Employee (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)
- ☐ 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)
- ☐ Covered employee is entitled to Medicare (36 mo. COBRA period)
- ☐ A dependent ceases to be a dependent as defined by the Employer's Group Plan (36 mo. COBRA period)
- ☐ Employer files for bankruptcy (Applies to retiree coverage only)

Employer Signature: _____ **Date:** _____

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

(Check One)

- ☐ Voluntarily dropping coverage
- ☐ Voluntarily dropping all spouse and/or dependent coverage
- ☐ Other group insurance without pre-existing conditions
- ☐ Retiring and entitled to Medicare with no spouse and/or dependents on current coverage, or spouse and/or dependents also entitled to Medicare
- ☐ Other (explain) _____

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: _____