Employee Enrollment for Dental and Vision Coverage

The Corinthian Plan
Together, providing health care for pastors and church workers

Mennonite Church USA Dental and Vision Plans

This form is to be used
- **If you have waived CEP health coverage and need to enroll in or waive dental and/or vision coverage.**
- **If you have enrolled in CEP health coverage, but need to waive dental and/or vision coverage.**

If your employer provides dental and/or vision coverage, you and your eligible family members will be automatically enrolled unless you have other dental or vision coverage.

THIS IS NOT AN APPLICATION FOR INSURANCE. It is an enrollment form for self-funded dental or vision coverage provided by your denomination.

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 _____
7. Number of hours paid per week _____
8. ☐ Credentialed ☐ Non-credentialed

To waive coverage

To waive coverage due to other dental or vision coverage, this section must be completed and signed.

9. ☐ I waive dental coverage for
   ☐ myself ☐ my spouse ☐ my dependents
10. Are all family members on the same dental plan?
    ☐ yes ☐ no
    If **no**, please explain.

    _____

    _____
11. ☐ I waive vision coverage for
    ☐ myself ☐ my spouse ☐ my dependents
12. Are all family members on the same vision plan?
    ☐ yes ☐ no
    If **no**, please explain.

    _____

    _____

Having waived coverage, I understand I and/or my family will be automatically enrolled in the dental and/or vision plan if eligibility for the other dental and/or vision plan is lost due to certain events which are outlined in the attached notice.

_____
Signature Date

To enroll in coverage

Dental coverage

13. Please give reason for **initial** enrollment in dental plan.
    - ☐ new hire
    - ☐ change in hours as of _____ *(date)*
    - ☐ loss of previous dental 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)*
    - ☐ open enrollment
14. If you are **adding family members to your existing dental coverage**, check the appropriate box and provide the dates requested.
    - ☐ Adding spouse; please give reason
      - ☐ loss of previous dental coverage as of _____ *(date)*
      - ☐ marriage as of _____ *(date)*
      - ☐ 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)*

Vision coverage

15. Please give reason for **initial** enrollment in vision plan.
    - ☐ new hire
    - ☐ change in hours as of _____ *(date)*
    - ☐ loss of previous vision 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)*
    - ☐ open enrollment

16. If you are **adding family members to your existing vision coverage**, check the appropriate box and provide the dates requested.
    - ☐ Adding spouse; please give reason
      - ☐ loss of previous vision coverage as of _____ *(date)*
      - ☐ marriage as of _____ *(date)*
      - ☐ 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)*

Complete Questions 17 to 23 only if you've waived the health coverage.

17. Home address _____
    street
    _____
    city state ZIP
18. Telephone number: _____
    Daytime (if different) _____
19. Email address _____
20. Birth date _____ 21. Age _____
    month day year
22. Gender ☐ M ☐ F
23. Marital status ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
24. Job title _____

Spouse and dependents (complete if to be covered)

25. Name (first, middle, last)	Social Security Number	Birth Date (month, day, year)	Gender
Spouse			
Dependent			
Dependent			
Dependent			

26. 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? _____

Employee certification and authorization

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

_____
Employee's signature Date

Notice of Special Enrollment Rights

Mennonite Church USA Dental and Vision Plans

Everence Association Inc., a fraternal benefit association, as claims administrator has prepared this notice on behalf of your dental and vision plans.

If your employer provides coverage under the Mennonite Church USA dental and/or vision plans and you or your dependents meet eligibility requirements, but are not enrolled in these plans, you will be automatically enrolled at a later time as outlined below.

Termination of employer contributions and loss of eligibility for other creditable coverage

If you and/or your dependents waive coverage under the dental and/or vision plans because you are enrolled in other dental or vision coverage, you and/or your dependents will automatically be enrolled in the Mennonite Church USA dental or vision plan later if employer contributions toward the other dental or vision coverage cease or if eligibility for the other coverage is lost as a result of any of the following events:

- Termination of employment.
- Involuntary termination of the other dental or vision coverage.
- Reduction in the number of hours of employment.
- Change in marital status such as marriage, legal separation, divorce, or death.
- The other dental or vision coverage discontinues dependent coverage.

You or your dependent will be enrolled in the applicable plan during the 90-day special enrollment period that immediately follows the day employer contributions cease or the other dental or vision coverage ends.

When new dependents become eligible for coverage

If you were not eligible to enroll in the dental or vision plan because you chose not to enroll in the Congregational Employee Plan, you will automatically be enrolled later at the same time a new dependent becomes eligible to be covered under the dental and/or vision plan because of marriage, birth, or adoption.* You and the new dependent will be enrolled in the applicable plan within the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the applicable plan.

In the same way, if your spouse is not enrolled in the dental or vision plan, he or she will automatically be enrolled later at the same time a newborn or newly adopted child becomes eligible to be covered under the dental and/or vision plan.* Your spouse and the new dependent will be enrolled in the applicable 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 waive coverage under the dental and/or vision plans because you are enrolled in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents will automatically be enrolled in the Mennonite Church USA dental and/or vision plan later if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents were not eligible to enroll in the dental or vision plan because you chose not to enroll in the Congregational Employee Plan, you and/or your dependents will automatically be enrolled later without being considered a late enrollee 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 dental and/or vision plan.*

You and/or your dependents will be enrolled in the applicable 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.

***Note:** Special enrollment will occur only if you enroll in the Congregational Employee Plan (or waive coverage in that plan due to having other health coverage) at the time of the qualifying event. You do not have special enrollment rights under the dental and/or vision plan if you do not enroll in or waive coverage in the Congregational Employee Plan.

To request special enrollment

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

Employee – keep this copy for your records.

Everence Association, Inc., a fraternal benefit society
1110 N. Main St.
P.O. Box 483
Goshen, IN 46527
everence.com
Toll-free: (800) 348-7468
T: (574) 533-9511