Employee Enrollment for Health Coverage

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

Congregational Employee Plan for Mennonite Church USA

The Corinthian Plan refers to the whole package of employee benefits. The health coverage is provided through the Congregational Employee Plan. THIS IS NOT AN APPLICATION FOR INSURANCE. It is an enrollment form for self-funded health coverage from your denomination.

Employer information

1. Employer _____
2. Employer location _____ (city) (state)

Employee information

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
9. Employee's address _____ (street)
   _____ (city) (state) (ZIP)
10. Telephone number: _____
    Daytime (if different) _____
11. Email address _____
12. Birth date _____ (month) (day) (year) 13. Age _____
14. Gender ☐ M ☐ F
15. Marital status ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
16. Job title _____

Please complete either Part A or Part B, depending on whether you're waiving or enrolling.

Part A: To waive health coverage

To waive coverage, this section must be completed and signed.

17. ☐ I waive health coverage for
    ☐ myself ☐ my spouse ☐ my dependents
18. I (we) have other creditable health coverage through
    ☐ a group health plan provided by my spouse's employer
    _____ (Name of plan)
    ☐ other group health plan coverage (provided by an employer other than the plan provided by your church)
    _____ (Name of plan)
    ☐ Individual health coverage*
    ☐ Part A or Part B of Title XVIII of the Social Security Act
    ☐ Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928
    ☐ Chapter 55 of Title 10, United States Code
    ☐ a medical care program of the Indian Health Service or of a tribal organization
    ☐ a state health benefits risk pool
    ☐ a health plan offered under Chapter 89 of Title 5, United States Code
    ☐ a public health plan established or maintained by a state, the U.S. government, or a foreign country
    ☐ a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))
    ☐ Title XXI of the Social Security Act (State Children's Health Insurance Program)
19. Are all family members on the same plan? ☐ yes ☐ no
    If no, please explain. _____

Having waived coverage, I understand I have the opportunity to enroll myself or my dependents later if I (we) lose other creditable coverage due to certain qualifying events which are outlined in the attached notice. I further understand that I (we) must enroll in the plan within the 90-day enrollment period which immediately follows a qualifying event. If I (we) do not enroll within the 90-day enrollment period, I (we) will be considered a late enrollee(s)**.

_____ (Signature) (Date)

** If you have individual health coverage, please note that this is not a valid waive. Therefore, you are not eligible to participate in life or disability plans or – if offered by your employer – the dental or vision plans.*

***Late enrollees may enroll in the plan as outlined in the paragraph entitled Enrolling at any other time on page 4.*

Part B: To enroll in health coverage

20. ☐ I request health coverage for
    ☐ myself ☐ my spouse ☐ my dependents
21. My spouse is also an employee of the congregation.
    ☐ yes ☐ no
    If yes, then ☐ Credentialed
    ☐ Non-credentialed
    Number of hours worked per week _____
    Number of hours paid per week _____
22. Please give reason and date for **initial** enrollment.
    ☐ new hire as of _____
    ☐ change in hours as of _____
    ☐ loss of previous creditable coverage as of _____
    ☐ marriage, birth or adoption of child as of _____
    ☐ loss of Medicaid/CHIP eligibility as of _____ ***(date)***
    ☐ eligible for premium assistance subsidy under Medicaid or CHIP as of _____ ***(date)***
    ☐ late enrollment – complete and attach a *Statement of Physical Condition* (only if age 19 or older)
    ☐ Open enrollment
23. If you are adding family members to **an existing policy**, check the appropriate box and provide the dates requested.
    ☐ Adding spouse; please give reason
    ☐ loss of previous creditable coverage as of _____
    ☐ marriage as of _____
    ☐ birth or adoption of child as of _____
    ☐ Adding new dependents
    reason for adding them at this time _____
    _____
    ☐ loss of Medicaid/CHIP eligibility as of _____ ***(date)***
    ☐ eligible for premium assistance subsidy under Medicaid or CHIP as of _____ ***(date)***
    ☐ late enrollment – complete and attach a *Statement of Physical Condition* (only if age 19 or older)
    ☐ Open enrollment

Spouse and dependents to be covered

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

25. 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? _____

Other medical insurance

26. Will anyone named on this enrollment form continue to have health coverage with another insurer after this plan goes into effect? ☐ yes ***(give details below)*** ☐ no
27. Will this coverage replace an existing health insurance policy for anyone named on this enrollment form?
    ☐ yes ***(give details below)*** ☐ no

Persons Covered	**Name of Other Health Insurance**	**Is this an Employer-Provided Policy?**	**To be Replaced?**	**Date of Replacement**
		☐ yes ☐ no	☐ yes ☐ no	
		☐ yes ☐ no	☐ yes ☐ no	

Employee certification, authorization, and application for membership

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 medical information to Everence and the claims administrator to certify medical treatment or process claims for myself, my spouse, or my dependents. I understand that Everence and the claims administrator will share this information with third parties only if necessary for managing or processing claims.

By my signature I am also applying for fraternal membership in Everence Association Inc., a fraternal benefit association.

_____
Employee's signature Date

Notice of Special Enrollment Rights

Congregational Employee Plan for Mennonite Church USA

Everence Association Inc., a fraternal benefit association, has prepared this notice on behalf of your health plan.

If you or your dependents are eligible for coverage under the Congregational Employee Plan (CEP) but choose not to enroll, you may have special rights to enroll at a later time without being considered a late enrollee, as outlined below.

Loss of eligibility for other creditable coverage

If you and/or your dependents waive coverage under this plan because you are enrolled in other creditable coverage[1], you and/or your dependents may enroll in this plan later (without being considered a late enrollee) if employer contributions toward the other creditable coverage cease or if eligibility for the other creditable coverage is lost as a result of any of the following qualifying events:

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

You and/or your dependents must enroll in this plan within the 90-day special enrollment period that immediately follows the day employer contributions cease or the other creditable coverage ends.

When new dependents become eligible for coverage

If you choose not to enroll in this plan, you may enroll later (without being considered a late enrollee) at the same time a new dependent becomes eligible to be covered under the plan because of marriage, birth, or adoption. You and the new dependent must enroll in this plan within the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

In the same way, if your spouse chooses not to enroll in this plan, he or she may enroll later (without being considered a late enrollee) at the same time a newborn or newly adopted child becomes eligible to be covered under the plan. Your spouse and the new dependent must enroll in this 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 this plan because you are enrolled in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents may enroll in the plan later (without being considered a late enrollee) if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible but choose not to enroll in this plan, you and/or your dependents may enroll in the plan 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 this plan.

You and/or your dependents must enroll in the 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.

Employee – keep this copy for your records.

continued

Enrolling at any other time
Any eligible individual who does not enroll in this plan within his or her respective 90-day enrollment or special enrollment period will be considered a late enrollee. A late enrollee age 19 or older may enroll during the plan year if proof of good health is provided and the individual is approved for coverage (a Statement of Physical Condition must be completed and attached) or a late enrollee may enroll during the annual open enrollment period. A late enrollee under age 19 may enroll at any time without providing proof of good health.

The open enrollment period begins Nov. 1 and ends Dec. 31. Coverage for a late enrollee who enrolls between Nov. 1 and Dec. 31 will be effective Jan. 1.

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

[1] *Creditable coverage includes a group health plan; health insurance coverage, including individual coverage; Parts A or B of Title XVIII of the Social Security Act (Medicare); Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan under Chapter 89 of Title 5, United States Code; a public health plan established or maintained by a state, the U.S. government, or a foreign country; a health benefit plan under Section 5(e) of the Peace Corps Act (22 U. S. C.2504(e)); or Title XXI of the Social Security Act (State Children's Health Insurance Program).*

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