UNIVERSAL BENEFIT FORM

Medical, Prescription,
Vision, Dental,
COBRA

NEW ENROLLMENTS, CHANGES, TERMINATIONS

BENECON
Benefit Administrators & Consultants

Instruction Sheet

IMPORTANT: The Universal Enrollment Form is a legal document that must be fully completed. Incomplete forms will be returned with missing sections highlighted. Email or phone updates to the form cannot legally be accepted. Please print clearly and legibly to avoid errors. You may sign and return for processing to Anne Walls via secure email (awalls@benecon.com) or fax (717-735-0133). If the termination is a COBRA qualifying event the employee or dependent will be notified of their right to elect COBRA once the completed form has been received and processed.

*****For all Benefit Form Submissions – Group Name, Group Number(s) and Effective date must be completed*****

***Section 3, please provide Plan Description (i.e. PPOS1, TRAS1, RXRS1) information on your benefit highlight sheet.**

Effective date: Please refer to your Plan Document for proper Termination dates and/or applicable waiting periods for Enrollment.

Enrollments: The following sections must always be completed for a New Enrollment –

Sections 1, 2, 3*, 10 and 11. (If HMO enrollment, complete Section 4)

If Applicable: For Medicare eligible subscribers, complete Section 6

For Handicapped dependents, complete Section 7

For other insurance, complete Section 8

Section 3: Please Provide Plan Description/Plan Option as listed on your Highlight Sheet, i.e. PPOS1, TRAS1, HMOS20, RXRS1

NOTE – For New Hires, please include both effective date and hire date. For additional dependents, please attach additional page.

Terminations: The following sections must always be completed for a Termination (Subscriber or Dependent) –

Sections 1, 2, 3, 5, 10, 11 and 12

NOTE – For any Termination please include Termination Event Date and Date Benefits End. For Terminations, Employer may sign in place of Employee in Section 10. A reason code MUST be selected and marked in the appropriate box on the second page.

Life Status Events: The following sections must always be completed for certain Life Status Events as listed below –

Newborn, Adoption, Divorce, Marriage, Dependent Addition (due to loss of other coverage)

Sections 1, 2, 3, 10 and 11

Address/Name Change: The following sections must always be completed for these changes –

Sections 1, 9 and 10

Rv. 1/2014

Universal Benefit Form
Medical, Prescription, Vision, Dental, COBRA

Group Name:

1.SUBSCRIBER INFORMATION:

☐ ENROLLMENT ☐COVERAGE CHANGE☐ TERMINATION ☐ ADDRESS/NAME CHANGE

MEDICAL GROUP NUMBER: **CLASS :** **(DEPENDENTS UP TO AGE 26)**
DENTAL GROUP NUMBER: **OPTION:** **(DEPENDENTS UP TO AGE 26)**
VISION GROUP NUMBER: **OPTION:** **(DEPENDENTS UP TO AGE 26)**

CHECK REASON CODE BOX ON REVERSE PAGE THAT APPLIES TO THE BOXES BELOW
☐ OPEN ENROLLMENT
☐ INITIAL ELIGIBILITY
☐ LIFE CHANGE EVENT
Effective Date of Change:

Subscriber Card ID or Social:	Birth Date	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
Subscriber Last Name	**Subscriber First Name**		**MI**

Does Employer employ 20 or more employees? ☐ Yes ☐ No

☐TERMINATION
☐ COBRA Qualifying Event

Effective Termination Event Date:

Effective Date Benefits End:
(Per Plan Document)

MAILING ADDRESS (Include street address, City, State & Zip Code):

Street:_____ *Phone(_____)*_____
City:_____***State:***_____***ZIP:***_____ ***New Address*** ☐ Yes ☐ No

Employment Status:
☐ Active (Full-Time) ☐ Retired – Date _____ ☐ Other – Explain _____

DATE HIRED:
EFFECTIVE DATE:
Has the Waiting Period Been met? ☐ Yes ☐ No

2. ENROLLMENT/CHANGE INFORMATION:

3. COVERAGE SELECTION/CHANGE (A to ADD, R to REMOVE)

4. PRIMARY CARE PHYSICIAN

First Name & Middle Initial (Show Last Name if different from Subscriber.	Soc Security #	Birth Date	ADD or REMOVE?	PPO	Trad	HMO	Senior	Drug	Dental	Vision	Indicate Practice Names & Codes Refer to Applicable Provider Directory — REQUIRED FOR HMO ONLY
SUBSCRIBER:		__/__ _/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #
Spouse: ☐ Male ☐ Female		__/_ __/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/__/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/__ _/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #
☐ Son ☐ Dau		__/_ __/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #
☐ Other		__/_ __/___	☐ Add ☐ Remove								Current Patient ☐ Yes ☐ No PCP Code #

5. FSA INFORMATION:

Is the member enrolled in a Flexible Spending Account (FSA)? ☐ Yes ☐ No
IF YES WHAT IS THE MONTHLY CONTRIBUTION AMOUNT $

6. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. (Refer to your red, white, and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.

Name of Subscriber or Dependent	*Medicare Claim Number*	*Effective Dates Hospital (Part A)*	*Effective Dates Medical (Part B)*	*Disabled?*	*ESRD?*	*Age*
		/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. HANDICAPPED DEPENDENTS	*8. OTHER INSURANCE COVERAGE*		
Name of Handicapped Dependent	*Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed).*		
	Name of Subscriber or Dependent	***Name of Health Care Plan/Insurance Co.***	***Identification/Policy Number***

9. CHANGE THE FOLLOWING INFORMATION	*Change is for ____ Subscriber _____Dependent*		*10. STATEMENT OF APPLICATION*
Name	*From*	*To*	***By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.***
Birth Date	*From* _____/_____/_____	*To* _____/_____/_____	
Social Security Number	*From* ___ ___ ___/___ ___/___ ___ ___ ___	*To* ___ ___ ___/___ ___/___ ___ ___ ___	_____ _____ ***Subscriber's Signature*** ***Date***

11. REASON CODES

INITIAL ELIGIBILITY
☐New group enrollment and/or group medical only benefit change.
☐Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group.
☐The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent).

LIFE STATUS CHANGES (If multiple changes occur, use the code most applicable)
☐The subscriber marries.
☐The subscriber has a child, adopts, acquires, a stepchild, or becomes legal guardian of a child.
☐The subscriber divorces and no longer has coverage through a spouse.
☐The subscriber has a change in employment status (i.e. from part-time to full-time, hourly to salary union to non-union).
☐The subscriber has a change in his/her Medicare Primary Status (employee retires and Medicare becomes primary).
☐The subscriber or dependent loses coverage under another benefit plan.
☐The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).

Other COBRA Qualifying Events
☐Employer Bankruptcy (Only with respect to retirees and their Dependents)
☐Employee eligible for TAA (Trade Adjustment Assistance) or ATAA (Alternative Trade Adjustment Assistance)
☐USERRA (Military Deployment) (**24 Month Eligibility)**

Terminations/COBRA Qualifying Events (18 eligibility
☐The subscriber is laid off ☐Reduction of Hours (Ft to Pt.)
☐Subscriber FMLA (Family Leave) expires
☐The subscriber no longer employed ☐Voluntary☐Involuntary

Terminations/COBRA Qualifying Event for Dependent (36 month eligibility)
☐Subscriber is deceased
☐Subscriber is Medicare Eligible
☐Subscriber has change in marital status (Divorce)
☐Dependent is over the age limit

Terminations/NON COBRA Qualifying Event
☐Subscriber has coverage with another insurance company
☐Dependent has coverage with another insurance company
☐Dependent is deceased
☐Gross Misconduct (not eligible for COBRA)

12. Severance, Medicare, and Disability

Is the employer paying any portion of the cobra premium: ☐ Yes ☐ No
If yes, end date of employer paid premiums:
If yes, total amount paid by employer: $ per month or ☐ 100%
Is this arrangement in addition to COBRA (consecutive) ☐, or part of COBRA (concurrent) ☐

Is the employee or any eligible dependents enrolled in Medicare? ☐ Yes ☐ No
If yes, please specify who is enrolled:
If yes, list Medicare Entitlement Date:

Are any Qualified Beneficiaries determined to be disabled by the Social Security Administration? ☐ Yes ☐ No
If yes, please specify name:
If yes, list Date of Determination:
Participants must provide copy of SSA letter.