CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446

Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

SPECIAL ENROLLMENT RIGHTS

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage, birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program **(CHIP)** due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

Please contact Liz Champ at the Diocesan Benefits Office (859-392-1554) if you have any questions regarding your enrollment in the CBEBT.

Christian Brothers Employee Benefit Trust History

The ***Christian Brothers Employee Benefit Trust (CBEBT)*** was established on January 1,1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The **CBEBT** has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The **CBEBT** is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with ***Christian Brothers Services*** to act as the Plan Administrator for the Trust. ***Health Benefit Services*** is the division of ***Christian Brothers Services*** that administers all the benefits plans funded by the Trust.

Christian Brothers Services Mission Statement

The Mission of ***Christian Brothers Services*** is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

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Email Completed Forms to: BENEFITS@COVDIO.ORG

Please read and fill out ALL applicable sections carefully.

1. Employer Section

Please print or type.

Location Name:		Location#:	
First Active Day of Work:		**Enrollment Use Only:** Effective Date of Coverage:	

2. Employee Section

Employee's Last Name:		Employee's First Name:	
Employee's Home Address:			
City:		State:	Zip Code:
Employee's Soc. Sec. #:		Date of Birth:	
Email Address:		Home Phone:	

☐ Male ☐ Female ☐ Religious ☐ Single ☐ Married ☐ Widowed ☐ Divorced

I request to be covered for the applicable benefits of my Group Plan as:

☐ Employee Only **or** ☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee, Spouse and Child(ren)

Please Complete section below if selecting dependent coverage. **Must be completed entirely or can result in delay.**

List the name of each dependent and answer each question for each dependent.	Social Security Number	Birthdate MM/DD/YY	Sex F/M	Are you legal Guardian	Step-child
Spouse:				**N/A**	**N/A**
List Children Below					
1.					
2.					
3.					
4.					
5.					
6.					

Signature of Employee:		Date:	

3. Waiver Of Group Coverage

I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:

☐ Myself ☐ My Dependents for Coverage(s) because:

☐ Enrolled on Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid
☐ Enrolled with another employer plan ☐ Other (please explain_____)

Effective Date:		Signature of Employee:		Date:	