You may fill out this form in Adobe Reader OR print it and fill it in by hand.

Print

General Board
Pension and Health Benefits

Caring For Those Who Serve

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
1-800-851-2201
www.gbophb.org

Choose one: ❑ HealthFlex ☒ Extend Health

HealthFlex Enrollment/Change Form

New hires and newly eligible participants must provide complete information on each eligible dependent. Enrolled participants making changes should provide only the information that has changed. If you wish for your mail to go to a different address, please see Part 11.

Part 1 – Participant/Plan Sponsor Information

Participant name _____ Social Security # _____

Legal address _____ Primary phone # _____

_____ Alternate phone # _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Civil Union[1] ❑ Domestic Partnership[1] Effective date of marital status _____

Conference/Plan Sponsor/Employer(s) Great Plains Conference Employer(s) # 335310

Membership: ❑ Clergy ❑ Lay Date of hire _____

Appointment/Employment status RETIRED Effective date _____

Percentage of employment: ❑ Quarter-time ❑ Half-time ❑ Three-quarters-time ❑ Full-time

Processing event code (please use codes listed in Part 10) _____ Event date _____

[1] This also applies to same-sex civil union partners or legal domestic partners of lay employees in states that have established civil unions or comprehensive state domestic partnerships if the plan sponsor has elected to provide such coverage through Exhibit D to its adoption agreement.

Part 2 – Election to Deduct Health Plan Contributions

(Optional—Only for participants receiving retirement or disability benefits)

Complete this section for participants who currently receive monthly retirement or disability benefit payments from plans administered by the General Board of Pension and Health Benefits (General Board). These participants may elect to pay their HealthFlex contributions via a deduction from their benefit payments.

❑ **Initial Deduction**

Amount to be deducted per month $ 0 Effective date _____

The amount indicated above will be deducted from the benefit payment I receive from one or more of the following plans: Clergy Retirement Security Program [CRSP, including the Ministerial Pension Plan (MPP) and Pre-82 Plan], United Methodist Personal Investment Plan (UMPIP), Comprehensive Protection Plan (CPP), Basic Protection Plan (BPP), and/or Retirement Plan for General Agencies (RPGA).

❑ **Change in Deduction**

Change from $ 0 per month to $ 0 per month Effective date _____

The new amount will be deducted from the benefit payment I receive from one or more of the following plans: CRSP, UMPIP, CPP, BPP and/or RPGA.

☒ **Not Applicable**

Note: When a death occurs, deductions are automatically stopped and will not be transferred to the surviving spouse's record. A new election form for the surviving spouse must be received by the General Board to transfer benefits.

3167/101212

Part 3 – Extend Health/Health Reimbursement Account (HRA) Amount

HRA Amount: Participant $ _____ Spouse/Dependent $ _____

(Please enter annual amount. Extend Health will prorate for partial years.)

Part 4 – Dependent Information

- List yourself and all eligible dependents, including your spouse[1], even if you are declining coverage. If you are currently enrolled and are adding/deleting a dependent, list only that dependent's information.
- Indicate whether you wish to cover yourself, your spouse and/or dependent children.
- If you are declining coverage for yourself or a dependent, indicate whether that person has other health coverage[2] and sign Part 7. (See the letter in your enrollment packet for the description of other health coverage. Use the description of "other employer-sponsored group health coverage" if you are a retiree.)
- Use Part 12 to provide information on additional dependents.

Name	Social Security #	Birth date	Relationship	Gender	Disabled Yes No	Cover Yes No	Other Health Coverage[2] Yes No
			self		❑ ❑	❑ ❑	❑ ❑
			spouse[1]		❑ ❑	❑ ❑	❑ ❑
			child		❑ ❑	❑ ❑	❑ ❑
			child		❑ ❑	❑ ❑	❑ ❑

[1] This also applies to same-sex civil union partners or legal domestic partners of lay employees in states that have established civil unions or comprehensive state domestic partnerships if the plan sponsor has elected to provide such coverage through Exhibit D to its adoption agreement.

[2] For retirees and dependents of retirees, "other health coverage" means other employer-sponsored group health coverage as described in the *HealthFlex Rules Regarding Retired Participants*.

Part 5 – Participant Signature

I attest that the above participant information is true to the best of my knowledge. In addition, if I am an active participant, I have received, read and I understand the HIPAA Notice of Special Enrollment Opportunity, the HealthFlex Notice of Pre-existing Condition Exclusions and the HealthFlex Notice of Privacy Practices, which are included in my New-Hire Enrollment Kit.

If I elected that my HealthFlex plan contribution be deducted from my retirement or disability benefit payment in Part 2, I hereby authorize the General Board of Pension and Health Benefits (General Board) to deduct the specific amount(s) I have elected and apply the entirety of such deducted amount(s) toward payment of any required contribution for which I am responsible under the terms of the group health plan known as "HealthFlex," or agreed upon between the General Board and annual conference for health plan contribution or insurance premium deductions.

I hereby acknowledge that in executing this instrument I am agreeing to release the General Board, its constituent corporations, directors, officers, attorneys and employees for liability to me, my spouse, my alternate payee, my heirs, named beneficiaries or successors in interest, for any damages which result from any action or omission taken in reliance on this instrument.

I authorize the General Board to make deductions from my benefit payment based on the election changes I make or increases or decreases in HealthFlex required contributions or other health plan contributions or insurance premiums.

Participant signature _____ Date _____

Part 6 – Plan Sponsor Authorization

Plan sponsor signature _____ Date _____

Part 7 – Declination of Coverage

If you are declining to cover yourself or any eligible dependents, it is important you understand certain plan rules. By declining coverage, you are declining coverage for the balance of the current plan year, and all subsequent plan years unless you enroll for such coverage during a subsequent annual election period for coverage commencing on the following January 1. Also, any persons for whom coverage is being declined will be subject to late entrant provisions under the plans, which include possible benefit limitations on pre-existing conditions. In certain circumstances, you may be able to enroll for coverage for yourself or eligible dependents prior to a subsequent annual election period. These circumstances include marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 and change of status rules under HealthFlex. If you understand the above and still wish to decline coverage for yourself or any eligible dependents, indicate whether those eligible persons for whom you are declining coverage currently have other health coverage in Part 4, and sign on the "Participant Signature" line below.

Once you are covered as a retired participant, you must maintain continuous coverage in the plan. If you terminate coverage for any reason, at any time while a retired participant, you will **permanently** lose eligibility to return to HealthFlex. Your spouse and dependents are subject to the same one-time election rule and other eligibility rules of your plan sponsor.

At the time of your retirement, you may postpone HealthFlex coverage for you and your eligible dependents if and only if you have other employer-sponsored group health coverage. If you wish to decline coverage for yourself or any eligible dependent, indicate whether the eligible persons for whom you are declining coverage currently have other employer-sponsored group health coverage in Part 4, and sign on the line immediately below.

Participant signature _____ Date _____

Part 8 – Retirees Only

❑ No change in information from previous *HealthFlex Enrollment/Change* form (for retirement HealthFlex benefit enrollment purposes only).

Part 9 – Default Rules for Retirees

If you do not complete and return this form to your plan sponsor, you are deemed to have refused coverage in retirement and you forfeit your eligibility under the plan.

Part 10 – Event Codes

	Event	Event Name
New Enrollment	1	New hire
	2	Newly eligible
	5	Special enrollment/new dependent
	6	Special enrollment/divorce
	7	Special enrollment/spousal death
	8	Special enrollment/spouse loses other coverage
Add Dependent for Covered Participant	3	New dependent
	4	Spouse loses other coverage
Delete Dependent for Covered Participant	9	Divorce
	14	Spouse gains other coverage
	17	Dependent child ineligible

	Event	Event Name
Death	33	Participant death
	34	Retiree death
	37	Dependent death
Termination	31	Declines coverage/non-payment
	36	Participant losing eligibility
Others	10	New Retiree
	11	Divorced spouse/legal decree
	21	Regaining eligibility/same plan year
	30	Late enrollment/annual election
	32	Retiree to active
	35	Continuation
	38	Other _____

Part 11 – Preferred Mailing Address[3]

Mailing address _____

_____

[3] If you are receiving retirement benefits and your state of residence for tax purposes is different than your mailing address, you must complete a *State Income Tax Withholding* form. Please contact the General Board for this form.

Part 12 – Additional Dependents

Name	Social Security #	Birth date	Relationship	Gender	Disabled Yes	Disabled No	Cover Yes	Cover No	Other Health Coverage[2] Yes	Other Health Coverage[2] No
			child		❑	❑	❑	❑	❑	❑
			child		❑	❑	❑	❑	❑	❑
			child		❑	❑	❑	❑	❑	❑
			child		❑	❑	❑	❑	❑	❑

[2] For retirees and dependents of retirees, "other health coverage" means other employer-sponsored group health coverage as described in the *HealthFlex Rules Regarding Retired Participants*.

Note: You can access a *Summary of Benefits and Coverage (SBC)* which summarizes important information about any health coverage option offered by your plan sponsor. The SBC is available at **www.gbophb.org**. A paper copy is also available, free of charge, by calling **1-800-851-2201**.