

GENERAL BOARD OF PENSION
AND HEALTH BENEFITS OF
THE UNITED METHODIST CHURCH

For Office Use Only:

Agr. I.D. # _____



1201 Davis Street
Evanston, Illinois 60201
847.869.4550

HealthFlex Enrollment/
Change Form for Participants

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 your mail to go to different address, please see Part 8.

Part 1 – Plan Sponsor Information

Participant name _____ Social Security # _____

Legal address _____ Home phone # _____

_____ Work phone # _____

Marital status: Single Married Divorced Widowed Effective date of marital status _____

Conference/Plan sponsor _____ Church/Employer _____

Membership _____ Membership effective date _____

Appointment/Employment: Status _____ Effective date _____

Percentage of employment: Quarter time Half time Three quarter time Full time

Processing event (please use codes listed in Part 7) _____ Event date _____

Plan eligibility date _____ Enrollment effective date _____

Part 2 – Dependent Information

1. List yourself and all eligible dependents, including your spouse, even if coverage is being declined. If you are currently enrolled and are adding/deleting a dependent, list only that dependent's information.
2. If a dependent child is age 19 or older, indicate whether he or she is a full-time student or disabled.
3. Indicate whether you wish to cover yourself, your spouse and/or dependent children.
4. If you are declining coverage on yourself or a dependent, indicate whether that person has other health insurance and sign Part 5. (See the letter in your enrollment packet for the description of other health insurance. Use the description of employer-sponsored group health insurance if you are a retiree.)

Name	Social Security #	Birth date	Relationship	Gender	Student*		Disabled*		Cover?		Other health insurance	
					Yes	No	Yes	No	Yes	No	Yes	No
_____	_____	_____	self	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	spouse	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	child	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* For dependent child(ren) over age 18 (Please see Part 9 for additional dependents.)

Part 3 – Participant Signature

I attest that the above participant information is true to the best of my knowledge.

Participant signature _____ Date _____

Part 4 – Plan Sponsor Authorization of Enrollment/Change

Plan sponsor signature _____ Date _____

(continued on back)

