MEDICAL & DENTAL INSURANCE ENROLLMENT / CHANGE FORM

CORE BENEFITS INC.
Quality, Compliance & Service

Employer	Plan Number	Soc Sec #
BROTHERS EXPRESS, INC.	20705100	

Name (First, MI, Last)	Date of Birth	Sex (M/F)

Street Address	City	State	Zip

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Plan A ☐ Plan B ☐ Plan C ☐ Dental

EMPLOYER SECTION

☐ Open Enrollment (original hire date_____) ☐ Late Enrollment
☐ Initial Enrollment (date employed full-time_____) ☐ Change of Information/Coverage
Number of hours worked per week_____ ☐ Termination/Reduction of hours
☐ Rehire (date re-employed full-time_____) (date_____)
☐ Special Enrollment - ☐ Marriage ☐ Newborn ☐ Adoption/Child placed for adoption
☐ Loss of other coverage Date of event_____ Attach documentation

PARTICIPANT INFORMATION

LIST THOSE DEPENDENTS TO BE COVERED

Relationship	Name (First, MI, Last)	Sex (M/F)	DOB	Medical	Dental	
Spouse				☐	☐	
Child				☐	☐	
Child				☐	☐	
Child				☐	☐	
Child				☐	☐	
Child				☐	☐	

CERTIFICATE OF PRIOR COVERAGE

Did you or your dependents have other coverage prior to this enrollment? ☐ Yes ☐ No
You (and your dependents) will be subject to pre-existing exclusions unless it can be established that you (and your family) have been covered by other insurance coverage for at least 12 months and have not experienced a "break in coverage" of 63 days or more. To establish this prior coverage, please provide a copy of the "Certificate of Prior Coverage" you received from your prior carrier. If you did not receive one, please request a copy and forward it to our office.

OTHER COVERAGE

Is other coverage provided for any family members? ☐ Yes ☐ No
Please provide the names of the individuals covered, the type of coverage provided and the company name:
_____
_____

BENEFICIARY INFORMATION

Name	Relationship
Address	
Contingent Beneficiary	Relationship
Address	

I declare that the above information is correct and true. I authorize payroll deduction on a pre-tax basis from my earnings for any contribution I am required to make.

_____ _____
Signature Date

DECLINATION OF COVERAGE

Note: You must complete this section if you decline coverage for yourself (if single) or family coverage (if married).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days of the event.

_____ _____
Signature Date

(260) 492-7292 Fax