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 9.

Part 1 – Participant/Plan Sponsor Information

Applicant name _____ Social Security # _____

Legal address _____ Primary phone # _____

_____ Alternate phone # _____

E-mail address _____

Marital status: ☐ Single ☐ Divorced ☐ Civil Union/ Domestic Partnership[1] ☐ Married ☐ Widowed

Effective date of marital status _____

Conference/Plan Sponsor/Employer(s) _____ Employer(s) # _____

Membership: ☐ Clergy ☐ Lay

Date of hire _____

Appointment/Employment status _____ Effective date _____

Percentage of employment: ☐ Quarter-time ☐ Half-time ☐ Three-quarters-time ☐ Full-time[2]

[1] This 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] Effective January 1, 2015, in accordance with the Affordable Care Act (ACA, i.e., the federal health care reform law), employers with 50 or more full-time equivalent employees are required, under the Employer Shared Responsibility Rule, to cover any full-time employees working 30 or more hours (e.g., ¾-time clergy) or else pay a penalty if any of those full-time employees receives a premium tax credit from a health insurance exchange. Please contact your conference benefits office for more information or if you have any questions.

Part 2 – Processing Event

Please check the processing event below. Event date _____

Life Status Event	Event Name	Life Status Event	Event Name
New Enrollment	❑ New hire ❑ Newly eligible ❑ New dependent ❑ Divorce ❑ Spousal death ❑ Spouse loses other coverage	Death	❑ Dependent death ❑ Participant death ❑ Retiree death
		Termination	❑ Declines coverage ❑ Non-payment ❑ Participant losing eligibility
Add Dependent for Covered Participants	❑ Dependent loses other coverage ❑ New dependent	Other	❑ Annual election ❑ Conference transfer ❑ Continuation ❑ Divorced spouse/legal decree ❑ Extend Health ❑ New retiree ❑ Regaining eligibility/same plan year ❑ Retiree to active ❑ Retiree—no change ❑ Other _____
Delete Dependent for Covered Participant	❑ Dependent child ineligible ❑ Dependent gains other coverage ❑ Divorce		

Part 3 – 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[3] and sign Part 7. (See the welcome 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 10 to provide information on additional dependents.

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover		Other Health Coverage[3]	
				F	M	Yes	No	Yes	No	Yes	No

[3] 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 4 – 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 $ _____ 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 $ _____ per month to $ _____ 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.

Part 5 – Extend Health/Health Reimbursement Account (HRA) Amount

HRA Amount: Participant $ _____ Spouse/Dependent $ _____

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

Part 6 – 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. 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 3, and sign on the "Participant Signature" line in Part 7.

Please make sure to check with your Plan Sponsor regarding the consequences and rules for declining health coverage as a retired participant.

Note 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 7 – Participant Signature

I attest that the 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Special Enrollment Opportunity and the HealthFlex Notice of Privacy Practices, which are included in my New-Hire Enrollment Kit.

If I am declining coverage, I hereby acknowledge I read, understand and accept the rules listed in Part 6 of this form.

I authorize the General Board to deduct the amount(s) I have elected in Part 4 and apply the deductions toward payment of my required contributions or health insurance premiums (contributions) under the terms of the applicable group health plan, either HealthFlex or, as agreed upon between the General Board and annual conference, the health plan maintained by the annual conference. I also authorize the General Board to make changes to these deductions based on any changes in contribution amount due to election changes or otherwise. I acknowledge that I am agreeing to release the General Board, its constituent corporations, directors, officers, attorneys and employees from 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.

Participant signature _____ Date _____

Part 8 – Plan Sponsor Authorization

Plan sponsor signature _____ Date _____

Part 9 – Preferred Mailing Address[4]

Mailing address _____

[4] 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 10 – Additional Dependents

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover		Other Health Coverage[3]	
				F	M	Yes	No	Yes	No	Yes	No

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**; log into **HealthFlex/WebMD** select "**HealthFlex Plan Benefits**," and search under "**Documents**."
A paper copy is also available, free of charge, by calling **1-800-851-2201**.