Universal Benefit Form

Medical, Prescription, Vision, Dental, COBRA

Enrollments, Changes, Terminations

Instructions

IMPORTANT: The Universal Benefit Form is a legal document that must be fully completed. Incomplete forms will be returned with missing sections highlighted. Email or phone updates to the form cannot legally be accepted. Please print clearly and legibly to avoid errors. You may sign and return for processing to accountservices@benecon.com or fax (888-977-2173). If the termination is a COBRA qualifying event the employee or dependent will be notified of their right to elect COBRA once the completed form has been received and processed.

For all Benefit Form Submissions

Group Name, Group Number(s) and Effective date must be completed

Effective date: Please refer to your Plan Document for proper Termination dates and/or applicable waiting periods for Enrollment.

Enrollments: The following sections must always be completed for a New Enrollment –
Sections 1, 2, 3*, 10 and 11. (If HMO enrollment, complete Section 4)
If Applicable: For Medicare eligible subscribers, complete Section 6
For Handicapped dependents, complete Section 7
For other insurance, complete Section 8

Section 3: Please Provide Plan Description/Plan Option as listed on your Highlight Sheet, i.e. PPOS1, TRAS1, HMOS20, RXRS1

NOTE – For New Hires, please include both effective date and hire date. For additional dependents, please attach additional page.

Terminations: The following sections must always be completed for a Termination (Subscriber or Dependent) –
Sections 1, 2, 3, 5, 10, 11 and 12

NOTE – For any Termination please include Termination Event Date and Date Benefits End. For Terminations, Employer may

sign in place of Employee in Section 10. A reason code MUST be selected and marked in the appropriate box on the second page.

Life Status Events: The following sections must always be completed for certain Life Status Events as listed below –

Newborn, Adoption, Divorce, Marriage, Dependent Addition (due to loss of other coverage)
Sections 1, 2, 3, 10 and 11

Address/Name Change: The following sections must always be completed for these changes –

Sections 1, 9 and 10

BENECON

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Group Name: _____

1. Subscriber Information:

☐ Enrollment ☐ Coverage Change ☐ Termination ☐ Address/Name Change

Medical Group Number: _____ Class: _____ (Dependents up to age 26)

Dental Group Number: _____ Option: _____ (Dependents up to age 26)

Vision Group Number: _____ Option: _____ (Dependents up to age 26)

Subscriber Card ID or Social:	Birth Date	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
_____	_____		

Subscriber Last Name _____ Subscriber First Name _____ MI _____

Mailing Address (Include street address, City, State & Zip Code):

Street: _____ Phone: _____

City: _____ State: _____ Zip: _____ New Address: ☐ Yes ☐ No

Employment Status:

☐ Active (Full-Time) ☐ Retired - Date: _____ ☐ Other - Explain: _____

Check reason code box on reverse page that applies to the boxes below.

☐ Open Enrollment
☐ Inital Eligibility
☐ Life Change Event

Effective Date of Change: _____

Does Employer employ 20 or more employees?

☐ Yes ☐ No

Date Hired: _____

Effective Date: _____

Has the Waiting Period Been Met?

☐ Yes ☐ No

☐ Termination
☐ COBRA Qualifying Event

Effective Termination Event Date: _____

Effective Date Benefits End: (Per Plan Document) _____

2. Enrollment/Change Information:

3. Coverage Selection/Change

4. Primary Care Physician

First Name & Middle Initial (Show Last Name if different from Subscriber.)	Social Security Number	Birth Date	("A" to Add "R" to Remove) ADD or REMOVE?	PPO	HDHP	HMO	Senior	Drug	Dental	Vision	Indicate Practice Names & Codes Refer to Applicable Provider Directory REQUIRED FOR HMO ONLY: Current Patient		PCP Code #
Subscriber:			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	
Spouse: ☐ Male ☐ Female			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Son ☐ Daughter			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Son ☐ Daughter			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Son ☐ Daughter			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Other			☐ Add ☐ Remove	☐	☐	☐	☐	☐	☐	☐	☐ Yes	☐ No	

5. FSA Information:

Is the member enrolled in a Flexible Spending Account (FSA)? ☐ Yes ☐ No

IF YES WHAT IS THE MONTHLY CONTRIBUTION AMOUNT $ _____

6. Medicare Coverage Information

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare.
(Refer to your red, white, and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)

Name of Subscriber or Dependent	Medicare Claim Number	Effective Dates: Hospital (Part A)	Effective Dates: Medical (Part B)	Disabled?	ESRD?	Age
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. Handicapped Dependents

Name of Handcapped Dependent

8. Other Insurance Coverage

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with any other insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed).

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

9. Change the Following Information

Change is for: ◯ Subscriber ◯ Dependent

Name	From:		To:	
Birth Date	From:		To:	
Social Security Number	From:		To:	

10. Statement of Application

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature _____ Date _____

11. Reason Codes

Initial Eligibility

- ☐ New group enrollment and/or group medical only benefit change.
- ☐ Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group.
- ☐ The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent).

Life Status Changes

(If multiple changes occur, use the code most applicable)

- ☐ The subscriber marries.
- ☐ The subscriber has a child, adopts, acquires, a stepchild, or becomes legal guardian of a child.
- ☐ The subscriber divorces and no longer has coverage through a spouse.
- ☐ The subscriber has a change in employment status (i.e. from part-time to full-time, hourly to salary union to non-union).
- ☐ The subscriber has a change in his/her Medicare Primary Status (employee retires and Medicare becomes primary).
- ☐ The subscriber or dependent loses coverage under another benefit plan.
- ☐ The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).

Other COBRA Qualifying Events

- ☐ Employer Bankruptcy (Only with respect to retirees and their Dependents)
- ☐ Employee eligible for TAA (Trade Adjustment Assistance) or ATAA (Alternative Trade Adjustment Assistance)
- ☐ USERRA (Military Deployment) (24 Month Eligibility)

Terminations/COBRA Qualifying Events (18 Eligibility)

- ☐ The subscriber is laid off ☐ Reduction of Hours (Ft to Pt.)
- ☐ Subscriber FMLA (Family Leave) expires
- ☐ The subscriber no longer employed ☐ Voluntary ☐ Involuntary

Terminations/COBRA Qualifying Event For Dependent

(36 Month Eligibility)

- ☐ Subscriber is deceased
- ☐ Subscriber is Medicare Eligible
- ☐ Subscriber has change in marital status (Divorce)
- ☐ Dependent is over the age limit

Terminations/Non COBRA Qualifying Event

- ☐ Subscriber has coverage with another insurance company
- ☐ Dependent has coverage with another insurance company
- ☐ Dependent is deceased
- ☐ Gross Misconduct (not eligible for COBRA)

12. Severance, Medicare, and Disability

Is the employer paying any portion of the COBRA premium? ☐ Yes ☐ No

If yes, end date of employer paid premiums: _____

If yes, total amount paid by employer: $ _____ per month or ☐ 100%

Is this arrangement in addition to COBRA (consecutive) ☐ , or part of COBRA (concurrent) ☐

Is the employee or any eligible dependents enrolled in Medicare? ☐ Yes ☐ No

If yes, please specify who is enrolled: _____

If yes, list Medicare Entitlement Date: _____

Are any Qualified Beneficiaries determined to be disabled by the Social Security Administration? ☐ Yes ☐ No

If yes, please specify name: _____

If yes, list Date of Determination: _____

Participants must provide copy of SSA letter.