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

**For Office Use Only:**
Agr. I.D. #____________

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Evanston, Illinois 60201
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# 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 X ____________ Social Security # X ____________

Legal address ____________ Home phone # ____________

____________ Work phone # ____________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective date of marital status ____________

Conference/Plan sponsor **Central Texas Conference** Church/Employer X ____________

Membership N/A Membership effective date N/A

Appointment/Employment: Status **Terminated/No longer eligible** Effective date ____________

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

Processing event (please use codes listed in Part 7) **31 / 36** Event date X ____________

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* Yes | Student* No | Disabled* Yes | Disabled* No | Cover? Yes | Cover? No | Other health insurance Yes | Other health insurance No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | self | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | spouse | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | child | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*(Please see Part 9 for additional space to list 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 X ____________ Date X ____________