# CBX Dental, Vision, & Voluntary Employee Enrollment Application



**Your company is a member of the following Exchange/Association**

❑ California Groundwater Assoc. ❑ California Tow Truck Assoc. ❑ Central Calif. ❑ El Dorado ❑ Kern ❑ Placer ❑ Santa Clara
❑ Santa Maria ❑ Shasta ❑ Stockton ❑ Ventura ❑ Valley Contractors Exchange ❑ Other_____

| **Enrollment Reason**: | | |
|---|---|---|
| ❑ New Hire<br>❑ Loss of Coverage (Date of Loss):_____<br>(HIPAA Certificate of Creditable Coverage Required) | ❑ New Firm Enrolling<br>❑ New Enrollment (OE) | ❑ Other Qualifying Event: _____<br>Event Date _____<br>❑ Rehire/Re-Enroll (90 day limit) |

## SECTION 1: EMPLOYEE INFORMATION

| **Full-Time Date of Hire:** | **Requested Effective Date:** | Effective date will be the 1st of the month following waiting period. |
|---|---|---|
| Name of Company | Job Title | |
| Last Name | First Name | M.I. |
| Social Security Number | **Date of Birth (mm / dd / yyyy)** | ❑ Male ❑ Female |
| Email Address | | Home Phone |
| Residence Address (Physical Address, no PO boxes) Apt # City State | | Zip Code |
| Mailing Address (If Different) Apt # City State | | Zip Code |
| Marital Status ❑ Married ❑ Single ❑ Domestic Partner | | |

## SECTION 2: BENEFIT SELECTION Please check below to enroll in the plans offered by your Employer.

If the company offers "Single Option", just select "Yes" or "No". If a Dual Option Choice is offered, also select the option you are choosing.

| **DENTAL PLAN:**<br>❑ Yes ❑ No<br>**If Dual Option**: ❑ DHMO ❑ PPO | **VSP PLAN:**<br>❑ Yes ❑ No<br>**If dual option:** ❑ Full Plan or<br>❑ Mtls Only (you must have KP medical.) | **BLUE VIEW VISION:**<br>❑ Yes ❑ No | **LANDMARK Chiro or Chiro/Acupuncture (Must Match Medical):**<br>❑ Yes ❑ No |
|---|---|---|---|

**VOLUNTARY BENEFITS:** (You can choose multiple voluntary plans if offered by your Employer)
❑ Hyatt Legal ❑ CADR+ ❑ LifeLock Identity Theft Protection ❑ LifeLock Ultimate

## SECTION 3: DEPENDENT ENROLLMENT INFORMATION Do you have any legal dependents? ❑ Yes ❑ No

If yes, are you enrolling any dependents in any combination of plans?
❑ No – Please cross out the dependent grid below and complete the declination on page 2.
❑ Yes – Please complete the dependent grid below for those to be enrolled.

| DEPENDENT GRID | SP/DP | CHILD #1 | CHILD #2 | CHILD #3 |
|---|---|---|---|---|
| **LAST NAME:** | | | | |
| **FIRST NAME**: | | | | |
| **SOCIAL SECURITY NUMBER:** | | | | |
| **DATE OF BIRTH:** | | | | |
| **GENDER:** | ❑ Male ❑ Female | ❑ Male ❑ Female | ❑ Male ❑ Female | ❑ Male ❑ Female |
| **RELATIONSHIP TO EMPLOYEE:** | ❑ SP ❑ DP | | | |
| **DISABLED:** [1] | | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **DEPENDENT ENROLLING IN:** [2] **(Only check plans that are offered)** | ❑ Dental ❑ Vision ❑ Chiro/Acu | ❑ Dental ❑ Vision ❑ Chiro/Acu | ❑ Dental ❑ Vision ❑ Chiro/Acu | ❑ Dental ❑ Vision ❑ Chiro/Acu |

[1] For disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.
[2] Dependents may enroll up to age 26 (except on MetLife if married or not a student and not living at home).

## SECTION 4: YOUR LEGAL ACKNOWLEDGEMENT: (Please Read, Sign and Date Below)

**Employee Statement** - I request group and/or voluntary coverage under my employer's group insurance plan as noted above and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

**X**

**EMPLOYEE SIGNATURE TO ENROLL IN COVERAGE** **DATE**

**PRINT NAME**

# Insurance Coverage Declination Form



**Please complete this form ONLY if you do not want coverage for yourself and/or your dependents.**

**SECTION A: PERSONAL INFORMATION** (to be completed by Employee)

| Name of Company | | Employer Phone Number |
|---|---|---|
| Employee Last Name | First Name | Middle Initial |
| Date of Hire | Employee Social Security Number | |

**SECTION B: TYPE OF DECLINATION** (check all that apply and include names of dependents)

| I am declining coverage for: | Dental | Vision | CHIRO/ACU* |
|---|---|---|---|
| ❑ Myself | ❑ | ❑ | ❑ |
| ❑ Spouse or ❑ Domestic Partner<br>Name: _____ | ❑ | ❑ | ❑ |
| ❑ Child(ren)<br>Name: _____ | ❑ | ❑ | ❑ |
| Name: _____ | ❑ | ❑ | ❑ |
| Name: _____ | ❑ | ❑ | ❑ |

* Note that if an employee waives the group's medical coverage due to other group coverage or state sponsored coverage and the group offers Landmark Healthplans for Chiro/Acu, the employee may choose to enroll in the Chiro/Acu through the CBX if allowed by the employer.

**SECTION C: REASON FOR DECLINING COVERAGE** (must be filled out completely)

❑ **Other Group Coverage through a Spouse/Domestic Partner**

| Plan | Carrier Name | Group # | Company Sponsor |
|---|---|---|---|
| **Dental** | | | |
| **Vision** | | | |
| **Chiro/Acu** | | | |

❑ Individual Coverage: ❑ Medicare ❑ Medi-Cal ❑ Individual Policy_____

❑ Other Reason: _____

**SECTION D: SPECIAL ENROLLMENT RIGHTS**

In certain circumstances, you and your eligible dependents may have rights to enroll outside the Open Enrollment period. To take advantage of special enrollment rights, you must request enrollment with the Contract Administrator (via your Employer) within 30 days of the event triggering special enrollment. Special enrollment rights may be triggered by any of the following events:

- If you or any of your dependents declined enrollment under this Plan because of other health insurance coverage, other than COBRA coverage, but afterwards lost eligibility for that coverage for any of the following reasons other than the failure to pay timely premiums or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan):
  - Loss of eligibility for coverage as result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of the employee, termination of employment, and reduction in the number of hours of employment;
  - The other plan ceases to offer any benefits to the class of similarly situated individuals that includes you or your dependent (e.g., your dependent is a part time employee with employer A and employer A discontinues coverage for part-time employees);
- If you are covered under another plan for which an employer makes a contribution towards your premium and that contribution is terminated (such contributions must be completely terminated; a reduction in the value of the benefit or an increase in cost to the participant does not trigger a special enrollment right); or
- You exhaust COBRA coverage; or
- If you acquire a new dependent(s) as a result of marriage or domestic partnership, birth, adoption or placement for adoption, you may be able to add the new spouse or domestic partner or child(ren), or enroll yourself and your dependents.

**SECTION E: YOUR LEGAL ACKNOWLEDGEMENT** By signing, I understand that by failing to elect coverage now, I will not be able to enroll until the next Open Enrollment period or a Qualifying Event occurs as stated above. This declination provision will not apply if a Court orders coverage of a spouse or child and the request for enrollment follows the Special Enrollment Rights guidelines as stated above.

**X** _____ _____

**EMPLOYEE SIGNATURE TO DECLINE COVERAGE** **DATE**

**PRINT NAME**