

# 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.  
  Central Coast  
  El Dorado  
  Kern  
  Placer  
 Santa Clara  
  Santa Maria  
  Shasta  
  Stockton  
  Ventura  
  Valley Contractors Exchange  
  Other \_\_\_\_\_

**Enrollment Reason:**

<input type="checkbox"/> New Hire <input type="checkbox"/> Loss of Coverage (Date of Loss): _____ (HIPAA Certificate of Creditable Coverage Required)	<input type="checkbox"/> New Firm Enrolling <input type="checkbox"/> New Enrollment (OE)	<input type="checkbox"/> Other Qualifying Event: _____ Event Date _____ <input type="checkbox"/> Rehire/Re-Enroll (90 day limit)
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**SECTION 1: EMPLOYEE INFORMATION**

Full-Time Date of Hire:	Requested Effective Date:	Effective date will be the 1 <sup>st</sup> 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)	<input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> 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.

<b>DENTAL PLAN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Dual Option:</b> <input type="checkbox"/> Base Plan <input type="checkbox"/> PPO Buyup	<b>VSP PLAN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If dual option:</b> <input type="checkbox"/> Full Plan or <input type="checkbox"/> Mtls Only (you must have KP medical.)	<b>BLUE VIEW VISION:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>LANDMARK Chiro or Chiro/Acupuncture (Must Match Medical):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
RELATIONSHIP TO EMPLOYEE:	<input type="checkbox"/> SP <input type="checkbox"/> DP			
DISABLED: <sup>1</sup>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT ENROLLING IN: <sup>2</sup> (Only check plans that are offered)	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu

<sup>1</sup> For disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.

<sup>2</sup> 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*
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child(ren) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* 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.

<b>X</b>	
<b>EMPLOYEE SIGNATURE TO DECLINE COVERAGE</b>	<b>DATE</b>

PRINT NAME