

PLEASE CHECK APPROPRIATE BOXES:

Status: **Active** **Annual Enrollment**
Retiree **New Enrollment**
COBRA **Add Dependent**
Delete Dependent
Special Enrollment

PLEASE PRINT



CSI INSURANCE PLAN

AND TRUST FUND

**CHRISTIAN SCHOOLS
INTERNATIONAL**

GROUP ENROLLMENT FORM

All applicants selecting dependent coverage must complete dependent information.
 If additional space is needed for dependents, attach a second form or a separate page.

Applicant's Name (Last, First, MI):		Social Security Number:	
Applicant's FULL Address: (Street)			
(City)		(State)	(Zip Code)
Telephone Number: ()		School Name:	
Birthdate:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married: Date _____ <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Sex: <input type="checkbox"/> male <input type="checkbox"/> female	Date of Employment:	Occupation:	

Have you or your spouse smoked cigarettes, cigars, pipes or used tobacco in any form during the past 12 months?	Self: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

Coverages Applying for:	Applicant	Spouse	Children
Medical: (Select One Plan)			
Plan C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO 90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO HSA1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO HSA2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retiree Coverage:			
- Under Age 65 (also select a plan above)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Age 65 and over (also select a plan below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retiree Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retiree Plan with Deductible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refusal of Coverages:
Applicant Spouse Children
Medical: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
I have been offered the above coverage and wish to decline enrollment for the following reason(s):
<input type="checkbox"/> Covered under Spouses insurance plan
<input type="checkbox"/> Other (please explain): _____

Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

1.	SPOUSE's Full Name: SSN:	Sex <input type="checkbox"/> f <input type="checkbox"/> m	Relationship: SPOUSE	Birthdate:	
2.	Dependent's Full Name: SSN:	Sex <input type="checkbox"/> f <input type="checkbox"/> m	Relationship: <input type="checkbox"/> child/step child <input type="checkbox"/> other _____	Birthdate:	Full Time Student <input type="checkbox"/> yes <input type="checkbox"/> no
3.	Dependent's Full Name: SSN:	Sex <input type="checkbox"/> f <input type="checkbox"/> m	Relationship: <input type="checkbox"/> child/step child <input type="checkbox"/> other _____	Birthdate:	Full Time Student <input type="checkbox"/> yes <input type="checkbox"/> no
4.	Dependent's Full Name: SSN:	Sex <input type="checkbox"/> f <input type="checkbox"/> m	Relationship: <input type="checkbox"/> child/step child <input type="checkbox"/> other _____	Birthdate:	Full Time Student <input type="checkbox"/> yes <input type="checkbox"/> no
5.	Dependent's Full Name: SSN:	Sex <input type="checkbox"/> f <input type="checkbox"/> m	Relationship: <input type="checkbox"/> child/step child <input type="checkbox"/> other _____	Birthdate:	Full Time Student <input type="checkbox"/> yes <input type="checkbox"/> no

I wish to apply for all coverages listed for which I am eligible under the group contract. I authorize payroll deductions for my share, if any, of the costs of the coverages applied for.

I understand that: in the event I desire at a later date, such coverages previously cancelled or refused, I will be required to furnish a late enrollee form and may be subject to an 18 month pre-existing condition exclusion.

APPLICANT'S SIGNATURE REQUIRED _____
DATE

**THIS CARD WILL NOT BE ACCEPTED
 UNLESS SIGNED AND DATED BY THE INSURED/APPLICANT.**

**PLEASE READ THE REVERSE SIDE FOR IMPORTANT INFORMATION REGARDING YOUR
 RIGHT TO SPECIAL ENROLLMENT AND PRE-EXISTING CONDITION LIMITATIONS.**

TO BE COMPLETED BY GROUP ADMINISTRATOR:

Group #: GE997	School #:	Region:	Division:	Class:	Effective Date:
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 Group Admin./Employer Signature _____
 Date



DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS AND PRE-EXISTING CONDITION LIMITATION

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Pre-existing Condition Limitation

This group health plan contains a pre-existing condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees) from the first day of coverage or of the waiting period, if any. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period which ends on the day before your coverage or the waiting period, if any, begins. This exclusion period may be reduced by the number of days of your prior creditable coverage. The plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certification(s) of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical healthcare program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, State Children's Health Insurance Program (S-CHIP), or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or HMO. If necessary, we will assist you in obtaining a certificate from any of these entities.

This Pre-existing Condition Limitation notice is being issued to you pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and reflects the protections afforded under federal law. If the state law applicable to your plan is more beneficial to covered individuals as to the length of the pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your plan.

You may contact us if you need additional information or assistance. All questions about pre-existing condition exclusions and creditable coverage should be directed to Trustmark Life Insurance, Affinity Markets Division, 400 Field Drive, Lake Forest, IL 60045.