WNCCUMC 2024 Open Enrollment

Please return to Treasury Services

healthgram

CLERGY/EMPLOYEE NAME AND ADDRESS:	ADDRESS CORRECTIONS:
	_____ _____ _____ _____ Your phone number (**mandatory**):_____

CURRENT COVERAGE:	NEW ELECTIONS: (MARK ELECTIONS BELOW)	
Employee ID: **Effective Date:** **Current Coverage:**	**Coverage Tier:** ☐ Single ☐ Emp + Spouse ☐ Emp + Children ☐ Family	**Plan:** ☐ Plan 6000 (former Basic) ☐ Plan 4000 (former Basic Plus) ☐ Plan 5500 HSA

NAME	R'ship	GENDER	SSN	BIRTH DATE	EFFECTIVE DATE	HAS OTHER INSURANCE	DROP COVERAGE
Information about you:							
_____	_____	_____	_____	_____	_____	☐	☐
Your dependents:							
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐

*Dependent SSNs are required.

Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another health plan? ☐ **YES** ☐ **NO**

Notice of Enrollment Rights
If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan 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. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee and will be subject to an eighteen (18) month waiting period before coverage can begin. 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.

Release of Medical Information
By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility insurance company or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Healthgram, Inc., if requested.

The terms of the plan have been explained to me and I have a complete understanding of my rights and responsibilities under the Plan. I hereby authorize my employer to make payroll deductions for the premium required for participation in the Plan (s) or their authorized representatives I affirm that the information is correct.

_____ _____

EMPLOYEE SIGNATURE **DATE**