EMPLOYEE ANNUAL CHANGE REQUEST
GROUP PLANS

Note: Complete and return this form to your employer to change your coverage option(s) to the plans listed below. Your employer will need to return this form to GuideStone®. The coverage available for your selection is contingent upon your employer's enrollment and participation in the plan. Please review the *Summary of Benefits and Coverage* for the medical plans offered by your employer.

EMPLOYEE INFORMATION (Please provide dependent information on the reverse side, if applicable.)

Employee first name: ______________ MI: ___ Last: ______________ Effective date: 1/1/2025

Employee mailing address: ______________

City: ______________ State: ______ ZIP code: ______

Social Security number: ______________ Email: ______________

Telephone: ______________ Classification: ______________ (e.g., ministerial, administrative)

Birthdate: ______________ Date of Initial Eligibility: ______________

Gender: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single

EMPLOYER INFORMATION

Employer name: ______________

Employer address: ______________

City: ______________ State: ______ ZIP code: ______

Employer number: ______________ Email: ______________

MEDICAL PLAN OPTIONS

Coverage option (please check)

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): ______________

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.
[2]This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older.

DENTAL PLAN OPTIONS

Coverage option (please check)

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): ______________

VISION PLAN OPTIONS

Coverage option (please check)

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): ______________

Continued on other side

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PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

An eligible spouse is a person of the opposite biological sex to whom you are legally married at the relevant time by civil or religious ceremony effective under the laws of the state in which the marriage was contracted. If an eligible spouse is over the age of 45 and does not have a social security number, an individual taxpayer identification number will be required for medical, dental, and/or vision enrollment. A copy of their ITIN assignment letter should accompany the enrollment form.

An eligible dependent child is a person under age 26 that is dependent on you or your spouse for support or maintenance and includes the following:

- Biological child
- Stepchild
- Foster child
- Child or grandchild for whom you or your spouse is the legal guardian or managing conservator
- Child whom you or your spouse must cover pursuant to a court or agency order or National Medical Support Notice under federal law
- Child 26 or over that is permanently incapacitated

Last name	First name	MI	Social Security Number	Birthdate	Relationship	Sex M/F	Medical Y/N	Dental Y/N	Vision Y/N	Dental ID Number†
			————	———	Self	—				

* Your spouse and children under age 26 are eligible for coverage.
† Cigna Dental Care DHMO only.

WAIVER OF MEDICAL, DENTAL, AND/OR VISION COVERAGE

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical, dental, and/or vision coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical, dental, and/or vision coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

I waive dental coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

I waive vision coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

Name: ____________________ Social Security number (last four digits): __________

Name: ____________________ Social Security number (last four digits): __________

Name: ____________________ Social Security number (last four digits): __________

AUTHORIZED SIGNATURES

Employee signature: ____________________ Date: __________

Employer's Authorized Representative signature: ____________________ Date: __________

☐ I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s), and GuideStone may require reimbursement for claims paid on behalf of ineligible enrollees.