40 Square
COOPERATIVE SOLUTIONS
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40 Square Health Plan

Change Form 2019

Please complete this form if you have a change in status (e.g., married, divorced, child born, etc.) and want to change, add or drop medical, dental, vision or life coverage for yourself or a dependent.

SECTION I - To be completed by employer

Employer Name	Employer Code
Employer Email Address	Employer Phone
Employee Name (Please print)	Social Security Number

Please note requested action to be taken

- ☐ Status Change - Add coverage (*See Section A)*
- ☐ Status Change - Drop coverage (*See Section A*)
- ☐ Termination of Employment (*See Section B*)
- ☐ Other _____

SECTION A - Select for Change in Status

The employee may change salary reduction and allocation of benefit during the plan year only if they experience a CHANGE IN FAMILY STATUS. If sometime during the year you are: (Check the appropriate change)

Date of Change _____

- ☐ Married
- ☐ Divorced
- ☐ Spouse commenced or terminated employment
- ☐ Death of a dependent
- ☐ Unpaid leave of absence by employee
- ☐ Unpaid leave of absence by spouse
- ☐ Return to full-time student
- ☐ Other _____

Contributions Change on Payroll Date _____

- ☐ A child is born or adopted
- ☐ A dependent child reaches the coverage limit of the plan
- ☐ Change in full-time or part-time employment for employee
- ☐ Change in full-time or part-time employment for spouse
- ☐ Return to work following leave of absence for employee
- ☐ Return to work following leave of absence for spouse
- ☐ No longer a full-time student

NOTE: Written proof of the change in status is required of the employee. Notify payroll of new salary reduction amount.

SECTION B - Select for Reason for Termination

Date of Event _____

- ☐ Termination of employment (Retirement, Layoff or Dismissal)
- ☐ Reduction in hours causing loss of eligibility
- ☐ Military Leave (31 days or longer)
- ☐ Medicare entitlement resulting in loss coverage
- ☐ Divorce or legal separation (ex-spouse mailing address)
- ☐ Disability
- ☐ Death of covered employee
- ☐ Dependent ceasing to be eligible under the Plan

Explanation of Other Charges _____

_____

SECTION II - Complete the following information for each individual with a change or termination

Name (Last, First, MI)	Date of Birth			Employee/ Spouse/Child	Gender (M/F)	Social Security Number **(Required)**	Request	Check For Each Dependent
	M	D	Y					
							☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life
							☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life
							☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision ☐ Life

If adding medical, dental or vision coverage, complete Section C (red). If adding life, complete Section D (red).
If dropping coverage, skip to SECTION III (black) and sign, date and return form.

40 Square Health Plan

Change Form 2019 (Continued)

SECTION C - Complete only if adding coverage

Medical Plan

- ☐ Employee $_____
- ☐ Spouse $_____
- ☐ Child 1 $_____
- ☐ Child 2 $_____
- ☐ Child 3 $_____
- ☐ Child 4 $_____
- ☐ Child 5 $_____
- ☐ I waive Medical coverage, I have other coverage
- ☐ I waive Medical coverage, I DO NOT have other coverage

Dental Plan

	Monthly Rates
☐ Employee	$39.08
☐ Employee + 1 Dependent	$78.68
☐ Employee + 2 or more Dependents	$141.48

- ☐ I waive Dental coverage, I have other coverage
- ☐ I waive Dental coverage, I DO NOT have other coverage

Vision Plan

	Plan (Choose one below)	Monthly Plan A Rates	Monthly Plan B Rates
☐ Employee	☐ Plan A	$9.40	$8.52
☐ Employee + 1 Dependent	☐ Plan B	$18.80	$17.01
☐ Employee + 2 or more Dependents		$26.92	$24.36

- ☐ I waive Vision coverage, I have other coverage
- ☐ I waive Vision coverage, I DO NOT have other coverage

NOTE: ***Employee must elect coverage to enroll Spouse or Dependent Children in any benefit.***

Please complete the "Other Insurance Inquiry Form" if you are electing Medical coverage on yourself and/or your dependents at this time and return with this form.

Employee Life Plan

- ☐ Employee Life Amount ($100,000) $_____
- ☐ Spouse Life Amount ($50,000) $_____
- ☐ Child Life Amount ($10,000) $_____
- ☐ I waive Elective Life coverage.

SECTION D - Complete only if adding life coverage

Primary	Relationship
Secondary	Relationship

List the FULL name and relationship of each beneficiary. If the beneficiary is not related to you, please provide their date of birth, social security number and full address on a separate piece of paper and attach to this form.

40 Square Health Plan

Change Form 2019 (Continued)

SECTION III - SIGNATURE (REQUIRED)

I hereby certify that the information I have provided above is true and correct and, I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents to EBSO, INC. for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee/Applicant Name _____ Social Security Number _____

Employee/Applicant Signature_____ Date _____

PERSON COMPLETING FORM (Please print)

Name	Date
Email	Phone

Please email form to:
info@40Square.coop

Or mail to:
EBSO, Inc.
Attention: 40 Square
2145 Ford Parkway, Suite 200
Saint Paul, MN 55116

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Other Insurance Inquiry Form

As a new enrollee, or as part of your plan renewal, we are required to obtain current Other Insurance Information. If you or your dependents are enrolled in the medical coverage under 40 Square Health Plan, this form must be completed and returned with your Enrollment Form before any claims can be processed. In the future, Other Insurance Information will normally be requested at your plan renewal, unless our information is incomplete or you have dependents who are full-time students. Other insurance may include, but is not limited to: coverage through a spouse's plan, court ordered insurance coverage by a former spouse, coverage required in a divorce decree or paternity suit, or Medicare. If you provide incorrect or inadequate information, claims may be delayed or denied.

SECTION I - OTHER INSURANCE INFORMATION

Please answer the question below. If you answer yes, please complete the rest of Section I.

Are any of your family members covered under any other group medical or Medicare? ☐ Single ☐ Married

If you checked yes, you must provide the following information. If you have more than one policy in force, please attach a separate sheet to this form which lists the following information for each policy.

Types of Coverage (Please check all that apply) ☐ Medical ☐ Medicare	Policyholder's Name	Policyholder's Birthdate
Policyholder's Employer Name	Address	Phone Number

Insurance Company Name and Phone Number	Policy Number	Family Members Covered

Names of Family Members Covered by Medicare	Medicare ID #

Medicare Part A Eff. Date / /	Medicare Part B Eff. Date / /	Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability

Is coverage for any of the above listed individuals required due to a court order, divorce decree or paternity suit? ☐ Yes ☐ No

If yes, please attach a copy of the section of the court order or divorce decree pertaining to health coverage. If you have previously provided this information to EBSO and that information is still current, you do not need to submit it again.

SECTION II - SIGNATURE

I hereby certify that the information I have provided above is true and correct and, I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents to EBSO, INC. for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee/Applicant Name _____ Social Security Number _____

Employee/Applicant Signature_____ Date _____