SPECIAL ENROLLMENT FORM

This application is used only for circumstances where health care coverage is being requested for an individual after an employee's or dependent's initial eligibility period has passed. If the employee is enrolling in Group Plans for the first time, a Group Plans Enrollment Form must accompany this form for enrollment.

RESET FORM

Special Enrollees

If an individual meets one of the following requirements, this person is a Special Enrollee:

- Loss of eligibility for other health care coverage; application for enrollment must be made within 60 days of the event.
- Acquisition of a dependent through marriage, birth, adoption or placement for adoption; application for enrollment must be made within 60 days of the event.

If approved, the coverage will become effective the day of the qualifying event.

GENERAL INFORMATION

Employer name: T Org Employer number: 71061

Employer city: Wheaton State: IL ZIP code: 60187-0969

Employee first name: _____ MI: ____ Last: _____

Employee classification: Select One

Birth date: _____/_____/_____ Social Security number: _____

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

Employee address: _____ City: _____ State: _____ ZIP code: _____

Email: _____ Home phone: (_____) _____

Coverage is being requested for (check all that apply):

☐ Self ☐ Spouse ☐ Dependent children

From the choices below, please indicate the reason coverage is being requested for you and/or your dependent(s):

☐ Loss of other health care coverage (indicate specific reason) First day without coverage _____/_____/_____

☐ Retirement ☐ End of COBRA eligibility ☐ Employer stopped contributions

☐ Death ☐ Divorce ☐ Termination of employment ☐ Other:_____

☐ Dependent addition (indicate specific addition) Date of event: _____/_____/_____

☐ Marriage ☐ Birth ☐ Adoption ☐ Placement for adoption

If adding a dependent please indicate if you would like to add life and/or dental coverage for Special Enrollee(s):

☐ Spouse life ☐ Child life ☐ Dental

Email to: *BenefitsHelp@Proton.me*

Continued on other side

Employee name: _____ Social Security number (last four digits): _____

COVERAGE REQUESTED

Select one: Medical Coverage

Select one

Select one: Dental Coverage (Not available to Mid Term Global Workers)

Select one

IF YOUR DEPENDENT(S) ARE TO BE COVERED, PROVIDE THE FOLLOWING INFORMATION*

Last name	First name	MI	Social Security Number	Date of birth	Relationship	Sex M/F

*Applicable to your spouse and any children under age 26.

COMPLETE SIGNATURE INFORMATION BELOW

I hereby request for my employer to arrange for the issuance of the benefits to which I am now entitled or to which I may become entitled under the terms of the group policy or policies issued to and/or administered by GSRF, and I authorize my employer to make the proper deductions, if any, from my earnings as my contribution toward the cost of this insurance.

Employee signature: _____ Date: _____/_____/_____

Employer authorized representative: _____ Date: _____/_____/_____

Copy this form as needed.