EBIDS TSM v1.0.0 20140220
VER 20140220vf
REV 20220630vf

Employee Benefits Information Data Sheet

PRINT

Applicant Information:

This is a fillable application - please complete this first page

Benefits Start Date: *mm / dd / yyyy* ___/___/___

Social Sec. #: *000-00-0000* ___-___-___

First: _____ MI: _____ Last: _____

Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

County: _____ Date of Birth: *mm / dd / yyyy* ___/___/___ Gender: ☐ M ☐ F

Home Phone: *123-456-7890* ___-___-___ Cell Phone: *123-456-7890* ___-___-___ Email: _____

Employer Information:

Date of Hire (or Your Company Start Date): *mm / dd / yyyy* ___/___/___

Owner of Company: _____ Choose a Tax ID Type: SSN *(000-00-0000)* FEIN*(00-0000000)*

(or Sole prop name)

Owner's Title: _____ Tax ID: N/A

Company: _____

Address: _____ Suite: _____

City: _____ State: _____ ZIP: _____

County: _____ Work Phone: *123-456-7890* ___-___-___ Work Fax: *123-456-7890* ___-___-___

Dependent Information:

	First Name	MI	Last Name	Gender	Date of Birth *mm / dd / yyyy*	Social Sec. # ***000-00-0000***
Spouse:				☐ M ☐ F	___/___/___	___-___-___
Child 1:				☐ M ☐ F	___/___/___	___-___-___
Child 2:				☐ M ☐ F	___/___/___	___-___-___
Child 3:				☐ M ☐ F	___/___/___	___-___-___
Child 4:				☐ M ☐ F	___/___/___	___-___-___

Date of Marriage: *mm/dd/yyyy* ___/___/___

Prior Coverage Information:

Prior Carrier: _____ From: *mm / dd / yyyy* ___/___/___ To: *mm / dd / yyyy* ___/___/___

Primary Care Doctor Name: _____

Primary Care Doctor (Spouse): _____ Referring Representative: Norman Michaels

Pediatric Doctor Name: _____ Today's Date: 06/28/2022

All information is kept confidential and will not be shared or used with any other company or organization.

Plan 8 - MagnaCare Ultra

Member Enrollment Form

CBG Chamber Benefits Group

A. Group Information (To be completed by the employer)				Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY
Group Number / Group Name	Plan CSP / Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐ On Leave of Absence ☐ Union Employee ☐ Retired ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the employee)	Employee/Subscriber	Spouse	Child	Child
Social Security Number:	--	--	--	--
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student	☐ Full-time Student
Prior Carrier (List coverage prior to this.) ☒ Same for all	Carrier: / Policy Number: / From Date / / / Thru date:: / /	/ /	/ /	/ /

C. Coordination of Benefits	Employee/Subscriber	Spouse	Child	Child
Medicare Coverage Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date:** / /	Policy Number: / Carrier: / Policy Holder: / Group Number: / BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: / Carrier: / Policy Holder: / Effective Date: / /	/ /	/ /	/ /

Employee's Address (Apt #)			**Employee's Signature**	Date
City	State	Zip	X	/ /

ENROLLMENT FORM

☐ NEW ☐ Addition ☐ Change* ☐ Termination* Effective Date ___/___/___ Plan Type: _____ (office use only)

(*If change selected, complete only Employee's Name, Social Security Number, and the Requested Change)
(*Termination date includes last day of coverage)

EMPLOYMENT INFORMATION

Employee Email:			
Employee Name Last: First: MI:	Sex ☐ M ☐ F	Date of Birth ___/___/___	Social Security Number - -
Home Telephone ( )	Employee Home Address Street/Apt. City State Zip		
Business Telephone ( )	Mailing Address if Different from Home Address Street/Apt. City State Zip		

Employee Status	Coverage Type	Check the Plan Options Selected			
		Medical	Dental	Rx Card	Vision
☐ Active ☐ COBRA ☐ Retiree ☐ Other	☐ Employee Only ☐ Family ☐ Employee + Dependent ☐ Other _____	☑			

List Full Name of your Eligible Dependents	Relation to Employee 2-Spouse 3-Child 3-Stepchild/ Other	Sex M or F	Date of Birth	Social Security Number	Other Employer Provided Insurance Available Y or N	Any Other Insurance Y or N	Please list Other Insurance and type of Coverage (Medical, Dental, Rx, Vision) for each Dependent with effective Date of Each
			//	--			
			//	--			
			//	--			
			//	--			
			//	--			

DEPENDENT EMPLOYER INFORMATION
(If your dependent or his/her spouse is employed, please provide the following information.)

Employer Name	Employer Address	Employer Phone Number

I verify that this information is true to the best of my knowledge and authorize my employer to deduct from my pay any required contributions.

Signature of Enrollee X _____ DATE Date: ___/___/___

Is employee eligible for Medicare?
☐ Yes ☐ No Effective Date
___/___/___

Is spouse/dependent eligible for Medicare?
☐ Yes ☐ No Effective Date
___/___/___

WAIVER OF COVERAGE:
I am electing at this time to waive coverage for myself ☐ and/or family ☐. I have coverage elsewhere and can provide proof if need be. I understand that by waiving coverage at this time I will not be eligible for benefits until the next open enrollment period.

Signature of Member: X _____ DATE Date: __/__/__

Any information that you provide concerning your eligibility under the Plan is a material representation to the Plan. Failing to provide truthful information may lead to a retroactive loss of coverage if such failure was due to fraud or a material misrepresentation. If coverage is terminated for fraud, misrepresentation, or the concealment of a material fact, the Plan has the right to recover any and all claim payments, including by means of offset against future benefits, and retains the right to pursue any/all other legal rights available.

EMPLOYER STATEMENT

Employer Name		Effective Date __/__/__
	Status: ☐ Active ☐ Retiree ☐ COBRA	Eligibility Class
Comments		Hire date __/__/__

TODAY'S DATE: _____
PROCESSED BY: _____

NEW FORM ☐
CHANGE FORM ☐

ENROLLMENT CHECKLIST

Member Name: _____

Employer: _____

Effective Date: // _____

Coverage Type: ☐ Single ☐ Employee + 1 ☐ Family

Other Employer Provided Insurance for Dependent: ☐ Yes ☐ No If Yes, is the Dependent eligible? **(select)**

Member Contact Number: HR Representative Number _____ **OR**

--

Member Contact Number -- _____

☐ Completed Enrollment Form ☐ Other Employer Provided Insurance Verification ☐ Health Form

☐ HIPAA Certificate

Previous Health Carrier: _____

Start Date: // _____ End Date: // _____

17764994.2

National Allied Workers Union, Local 831

125 Windsor Drive, Suite 118, Oak Brook Illinois 60523

I have been advised, and understand that I am not required to sign any dues check-off assignment, or any membership application card, or any other Union form, and I further realize that under the provisions of the Labor-Management Relations Act of 1947, as amended, and the contract between the above Local Union and my Employer, I am not required, as a condition of employment or participating in the association, to become a member of said Union until the thirtieth (30) day following the beginning of my employment or the effective date of such contract, whichever is the later, nevertheless, I desire, voluntarily to sign this form.

I, the undersigned, hereby apply for membership in the above Union.

Employee's Signature: X _____

I (Print Name) _____ the undersigned, authorize and

Irrevocably direct (Name of Company) _____ to

deduct from my wages each and every month dues and initiation fees which may be charged against me by National Allied Workers Union Local 831, which is required to maintain me as a member in good standing in said Union, in accordance with the By-Laws of the Union and in compliance with the Labor Management Relations Act of 1947. The amount deducted each month shall be forwarded to the authorized agent of National Allied Workers Union Local 831.

This authorization and direction shall be irrevocable until the termination of the collective bargaining agreement between my Employer and National Allied Workers Union.

Employee's Signature X _____

Address: _____

_____

Starting Date: // _____ Date Signed: ____/____/____

Social Security Number: ___-- _____