❒ New Enrollee

❒ Change of Enrollment

CEBT Enrollment / Change Form

Please type or print in ink. ***Employer – Complete all shaded areas at the top of the card.*** ***Employee – Complete non shaded areas.***

Name or employer	Date of Eligibility	Eff. Date (Required)	Salary	Life Volume	Branch #

1. Employee's Name (last, first, middle initial)	2. Social Security #	3.Date of Birth

4. Employee's mailing address Street City State Zip	5. Male ❒ Female ❒

6. Beneficiary's name	7. Relationship to you

8.	PPO						HDHP			EPO			KP	HRP	DENTAL	VISION	LIFE	DEP
	2	3	4	5	6	7	2700	3500	5000	3	4	5						LIFE
Employee Only	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
Employee & Spouse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐		☐
Employee & Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐		☐
Employee & Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐		☐
Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐		☐

If you are enrolling in Kaiser you will also need to complete the Kaiser enrollment application.

☐ Check here to indicate Kaiser election form is attached

Please access a copy of the new Summary of Benefits and Coverage (SBC) at www.cebt.org.

9. Do you want dependent coverage? yes ❒ no ❒ If yes, complete below and provide proof of legal dependency such as Certificates of birth, marriage, common law, civil union and adoption.

Last, First	Social Security Number (Required)	Date of Birth	Gender	Enrolled in Medicare?
1 .Spouse				Y / N
2. Dependent Child				Y / N
3. Dependent Child				Y / N
4. Dependent Child				Y / N
5. Dependent Child				Y / N
6. Dependent Child				Y / N

10. PLEASE CHECK ONE:

Add Spouse ❒ Effective Date _____ Marriage ❒ Drop Spouse ❒ Effective Date _____ Divorce ❒

Add Dependent(s) ❒ Drop Dependent(s) ❒ Beneficiary Change ❒ Name Change ❒ Address Change ❒

***CEBT Hospital Reimbursement Plan (HRP) Acknowledgement**

I have read, understand and agree that by enrolling in the CEBT Hospital Reimbursement Plan (HRP) that this coverage will be secondary. The HRP will only pay benefits for unreimbursed eligible hospital expenses after my primary plan has processed the charges. The benefits under the HRP will be up to a $1,000 per day and up to $30,000 calendar year maximum.

I have read and understand the benefits information provided and I am aware that changes may only be made during the annual open enrollment period of if I have a HIPAA qualifying event.

11. Employee's signature _____ Home Phone # _____ 12. Date Signed _____

10/2017