



2007 Open Enrollment

Health Benefit Enrollment Form

united methodist church southwest texas conference
board of pensions
16400 huebner rd san antonio tx, 78248

BENEFITS ADMINISTERED BY:
BENEFIT PLANNERS INC - GROUP #98122 www.benplan.com

LOCAL CHURCH		DATE OF HIRE	EFFECTIVE DATE OF TRANSACTION	
PARTICIPANT (Last, First, Middle)		ENROLLMENT		TERMINATION
SOCIAL SECURITY #		<input type="checkbox"/> New Employee		<input type="checkbox"/> Termination of Employment
DATE OF BIRTH		<input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Open Enrollment
HOME PHONE		<input type="checkbox"/> Reinstatement / Rehired		<input type="checkbox"/> Death
WORK PHONE				<input type="checkbox"/> Retirement
				<input type="checkbox"/> Other
CHANGE				
<input type="checkbox"/> Change Address				
<input type="checkbox"/> Add / Remove Dependents				
<input type="checkbox"/> Appointment Change				
<input type="checkbox"/> Active to Retired Status				
<input type="checkbox"/> *Family Status Change				
Date: _____				

ADDRESS	CITY	STATE	ZIP	*FAMILY STATUS CHANGE	
GENDER		MARITAL STATUS		EMPLOYMENT STATUS	
<input type="checkbox"/> Male		<input type="checkbox"/> Married		<input type="checkbox"/> Clergy	
<input type="checkbox"/> Female		<input type="checkbox"/> Single		<input type="checkbox"/> Conference Lay	
				<input type="checkbox"/> Local Church Lay	
				<input type="checkbox"/> Retiree	
				<input type="checkbox"/> Marriage	
				<input type="checkbox"/> Reduction / Increase Hours	
				<input type="checkbox"/> Death	
				<input type="checkbox"/> Spouse Loss of Coverage	
				<input type="checkbox"/> Birth	
				<input type="checkbox"/> Spouse Employment Change	
				<input type="checkbox"/> Adoption	
				<input type="checkbox"/> Other	

MEDICAL / DENTAL	LIFE INSURANCE / ADD - LIFE INSURANCE BENEFITS DO NOT APPLY TO RETIRED PARTICIPANTS		
<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> Volume \$15,000	LIFE INSURANCE PRIMARY BENEFICIARY (Full Name)	
<input type="checkbox"/> SPOUSE	<input type="checkbox"/> Volume \$5,000	RELATIONSHIP / SOCIAL SECURITY #	
<input type="checkbox"/> CHILD(REN)	Life / ADD apply only to ACTIVE covered participants & dependents	LIFE INSURANCE SECONDARY BENEFICIARY (Full Name)	
<input type="checkbox"/> FAMILY		RELATIONSHIP / SOCIAL SECURITY #	

Changes: Check 'Add' to add a dependent and provide dependent details. Check "Cancel" to delete a covered dependent from the plan.

ADD/ CANCEL	DEPENDENT NAME Full-Name	DATE OF BIRTH SOCIAL SECURITY #	GENDER	RELATIONSHIP	OTHER INSURANCE If Yes, Provide Name of Carrier
<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL		/	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL		/	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL		/	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL		/	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> YES <input type="checkbox"/> NO

Pre-existing condition limitations do not apply to members who elect coverage at their initial eligibility date.

Proof of Creditable Coverage Notice: Under the Health Insurance Portability and Accountability Act (HIPAA), individuals have a right to demonstrate prior health coverage to reduce the Plan's pre-existing condition limitation period by providing Proof of Creditable Coverage. The Plan's pre-existing condition exclusion period will be reduced by a period equal to the period of any creditable coverage as long as there is no break in coverage of 63 days or more. Waiting periods are not considered a break in coverage. Proof of Creditable Coverage should be issued by your previous health plan administrator and should be submitted with this enrollment form when applying for coverage.

AUTHORIZATION: I hereby authorize any health care provider, insurance company, the Medical Information Bureau, or other organization, institution, or person that has any information regarding claims or the facts contained herein to release to claims administrator any and all such information. A Photo copy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization upon request.

ACKNOWLEDGMENT: I acknowledge that the above referenced Employer Plan (The Plan) is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays on my claim. I will not release any responsible party from liability without the Plan's written approval. I agree to reimburse The Plan to the extent of the amount paid on claims under any non-occupational benefit provision under any Worker's Compensation law or similar legislation.

My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge. I understand that any misrepresentation of a material fact on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable.

SIGNATURE OF EMPLOYEE	LOCAL CHURCH BENEFIT ADMINISTRATOR	DATE
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For Office use only Date:

Division:

Plan Type:

Board of Pensions
United Methodist Church Southwest Texas Conference

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Board of Pensions of the United Methodist Church of the Southwest Texas Conference (Hereinafter referred as the Board) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our participants with notice of our legal duties and privacy procedures with respect to your protected health information.

Disclosure of your Health Care Information

- Workers' Compensation

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

- Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation & Research.

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.

In the event that the Board is merged with another organization, your health information/record will become the property of the new organization.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the Board is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that the Board amend your protected health information. Please be advised, however, that the Board is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by the Board.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

The Board reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the Board is required by law to comply with this Notice.

Board is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: David A. Seilheimer, Privacy Officer by calling this office at 210-408-4500. If David A. Seilheimer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights, or how the Board has handled your health information should be directed to David A. Seilheimer by calling this office at 210-408-4526. If David A. Seilheimer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of November 5, 2005