

Universal Benefit Form

Medical, Prescription, Vision, Dental, COBRA Enrollments, Changes, Terminations

Instructions

IMPORTANT: The Universal Benefit Form is a legal document that must be fully completed. Incomplete forms will be returned with missing sections highlighted. Email or phone updates to the form cannot legally be accepted. Please print clearly and legibly to avoid errors. You may sign and return for processing to accounts@benecon.com or fax (888-977-2173). If the termination is a COBRA qualifying event the employee or dependent will be notified of their right to elect COBRA once the completed form has been received and processed.

For all Benefit Form Submissions

Group Name, Group Number(s) and Effective date must be completed

Effective date: Please refer to your Plan Document for proper Termination dates and/or applicable waiting periods for Enrollment.

Enrollments: The following sections must always be completed for a New Enrollment –
Sections 1, 2, 3*, 10 and 11. (If HMO enrollment, complete Section 4)

If Applicable: For Medicare eligible subscribers, complete Section 6
For Handicapped dependents, complete Section 7
For other insurance, complete Section 8

Section 3: Please Provide Plan Description/Plan Option as listed on your Highlight Sheet, i.e. PPOS1, TRAS1, HMOS20, RXRS1

NOTE – For New Hires, please include both effective date and hire date. For additional dependents, please attach additional page.

Terminations: The following sections must always be completed for a Termination (Subscriber or Dependent) –
Sections 1, 2, 3, 5, 10, 11 and 12

NOTE – For any Termination please include Termination Event Date and Date Benefits End. For Terminations, Employer may

sign in place of Employee in Section 10. A reason code MUST be selected and marked in the appropriate box on the second page.

Life Status Events: The following sections must always be completed for certain Life Status Events as listed below –

Newborn, Adoption, Divorce, Marriage, Dependent Addition (due to loss of other coverage)
Sections 1, 2, 3, 10 and 11

Address/Name Change: The following sections must always be completed for these changes –
Sections 1, 9 and 10

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Universal Benefit Form

Medical, Prescription, Vision, Dental, COBRA

Group Name: _____

1. Subscriber Information:

☐ Enrollment ☐ Coverage Change ☐ Termination ☐ Address/Name Change

Medical Group Number: _____ Class: _____ (Dependents up to age 26)

Dental Group Number: _____ Option: _____ (Dependents up to age 26)

Vision Group Number: _____ Option: _____ (Dependents up to age 26)

Subscriber Card ID or Social: _____

Birth Date _____

☐ Male

☐ Female

☐ Single

☐ Married

☐ Domestic Partner

Subscriber Last Name _____

Subscriber First Name _____

MI _____

Mailing Address (Include street address, City, State & Zip Code):

Street: _____ Phone: _____

City: _____ State: _____ Zip: _____ New Address: ☐ Yes ☐ No

Employment Status:

☐ Active (Full-Time)

☐ Retired - Date: _____

☐ Other - Explain: _____

Check reason code box on reverse page that applies to the boxes below.

☐ Open Enrollment

☐ Initial Eligibility

☐ Life Change Event

Effective Date of Change: _____

Does Employer employ 20 or more employees?

☐ Yes ☐ No

Date Hired: _____

Effective Date: _____

Has the Waiting Period Been Met?

☐ Yes ☐ No

☐ Termination

☐ COBRA Qualifying Event

Effective Termination Event Date: _____

Effective Date Benefits End:
(Per Plan Document)

2. Enrollment/Change Information:

First Name & Middle Initial (Show Last Name if different from Subscriber.)	Social Security Number	Birth Date
Subscriber:		
Spouse:		
<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Son		
<input type="checkbox"/> Daughter		
<input type="checkbox"/> Son		
<input type="checkbox"/> Daughter		
<input type="checkbox"/> Son		
<input type="checkbox"/> Daughter		
<input type="checkbox"/> Other		

3. Coverage Selection/Change

("A" to Add "R" to Remove)									
ADD or REMOVE?	PPO	HDHP	HMO	Senior	Drug	Dental	Vision		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

4. Primary Care Physician

Indicate Practice Names & Codes Refer to Applicable Provider Directory REQUIRED FOR HMO ONLY		
Current Patient	PCP Code #	
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

5. FSA Information:

Is the member enrolled in a Flexible Spending Account (FSA)? ☐ Yes ☐ No

IF YES WHAT IS THE MONTHLY CONTRIBUTION AMOUNT \$ _____

6. Medicare Coverage Information

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare.

(Refer to your red, white, and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)

Name of Subscriber or Dependent	Medicare Claim Number	Effective Dates		Disabled?	ESRD?	Age
		Hospital (Part A)	Medical (Part B)			
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Handicapped Dependents		8. Other Insurance Coverage		
Name of Handcapped Dependent		Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with any other insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed).		
		Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

9. Change the Following Information		Change is for: <input type="radio"/> Subscriber <input type="radio"/> Dependent	
Name	From:	To:	
Birth Date	From:	To:	
Social Security Number	From:	To:	

10. Statement of Application	
By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.	
Subscriber's Signature	Date

11. Reason Codes	
Initial Eligibility <input type="checkbox"/> New group enrollment and/or group medical only benefit change. <input type="checkbox"/> Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group. <input type="checkbox"/> The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent).	Terminations/COBRA Qualifying Events (18 Eligibility) <input type="checkbox"/> The subscriber is laid off <input type="checkbox"/> Reduction of Hours (Ft to Pt.) <input type="checkbox"/> Subscriber FMLA (Family Leave) expires <input type="checkbox"/> The subscriber no longer employed <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary
Life Status Changes (If multiple changes occur, use the code most applicable) <input type="checkbox"/> The subscriber marries. <input type="checkbox"/> The subscriber has a child, adopts, acquires, a stepchild, or becomes legal guardian of a child. <input type="checkbox"/> The subscriber divorces and no longer has coverage through a spouse. <input type="checkbox"/> The subscriber has a change in employment status (i.e. from part-time to full-time, hourly to salary union to non-union). <input type="checkbox"/> The subscriber has a change in his/her Medicare Primary Status (employee retires and Medicare becomes primary). <input type="checkbox"/> The subscriber or dependent loses coverage under another benefit plan. <input type="checkbox"/> The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).	Terminations/COBRA Qualifying Event For Dependent (36 Month Eligibility) <input type="checkbox"/> Subscriber is deceased <input type="checkbox"/> Subscriber is Medicare Eligible <input type="checkbox"/> Subscriber has change in marital status (Divorce) <input type="checkbox"/> Dependent is over the age limit
Other COBRA Qualifying Events <input type="checkbox"/> Employer Bankruptcy (Only with respect to retirees and their Dependents) <input type="checkbox"/> Employee eligible for TAA (Trade Adjustment Assistance) or ATAA (Alternative Trade Adjustment Assistance) <input type="checkbox"/> USERRA (Military Deployment) (24 Month Eligibility)	Terminations/Non COBRA Qualifying Event <input type="checkbox"/> Subscriber has coverage with another insurance company <input type="checkbox"/> Dependent has coverage with another insurance company <input type="checkbox"/> Dependent is deceased <input type="checkbox"/> Gross Misconduct (not eligible for COBRA)

12. Severance, Medicare, and Disability	
Is the employer paying any portion of the COBRA premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, end date of employer paid premiums: _____	
If yes, total amount paid by employer: \$ _____ per month or <input type="checkbox"/> 100%	
Is this arrangement in addition to COBRA (consecutive) <input type="checkbox"/> , or part of COBRA (concurrent) <input type="checkbox"/>	
Is the employee or any eligible dependents enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify who is enrolled: _____	
If yes, list Medicare Entitlement Date: _____	
Are any Qualified Beneficiaries determined to be disabled by the Social Security Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify name: _____	
If yes, list Date of Determination: _____	
Participants must provide copy of SSA letter.	