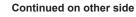
EMPLOYER ANNUAL ELECTION FORM GROUP PLANS

Complete this form and return to Insurance Plans by 10/26/2023 for changes that will be effective 1/1/2024.

1. EMPLOYER INFORMATION			
Employer name:			
Employer number:			State:
IMPORTANT: Please fill out the sections below to plans not changing.	o reflect all plan options you wil	ll be offering in 2024	, including new plans and
2. MEDICAL PLAN OPTIONS			
1. Are you adding, deleting or changing any medica	al products?	☐ Yes [□ No
2. Are you adding, deleting or changing any medica	☐ Yes [□ No	
3. Are you adding, deleting or changing any medica	ents?	□ No	
4. Are you making changes to the current continua	☐ Yes [□ No	
If you selected "Yes" to question 1, 2 or 3, pleas	se fill out the information below		
Please limit your medical plan choices to no mo please contact your Insurance Plans relationship m		like to discuss a nee	d for multiple plan designs,
EMPLOYER	CONTRIBUTION PERCENTAGE	/AMOUNT	
Employee Class	Plan	Employer Contribution for Employee	tion Employer Contribution for Dependent
These plans do not constitute "creditable coverage" for M			
This plan does not constitute "creditable coverage" for a late enrollment penalties from Medicare.	ctive members age 65 and older unde	r Medicare Part D. Part	cipants in this plan could incur
These plans are closed to newly enrolling groups.			
Notes:			







Employer name:		Employer number:		
3. MEDICARE-COORDINATING PLAN OPTION	IS			
1. Are you adding, deleting or changing any Medicare-coordinating plan products?			☐ Yes ☐ No	
2. Are you adding, deleting or changing any Me	Are you adding, deleting or changing any Medicare-coordinating plan classes?			
3. Are you adding, deleting or changing any Me	Are you adding, deleting or changing any Medicare-coordinating plan contribution amounts/arrangements?			
f you selected "Yes" for any of these questi	ons, please fill out the info	ormation below.		
EMPLOY	ER CONTRIBUTION PERC	ENTAGE/AMOUNT		
Employee Class	Plan	Employer Contrib for Employee	ution Employer Contribution for Dependent	
To maintain eligibility for the Senior or Senior Plus ploins the Senior or Senior Plus plan effective 1/1/2009 4.DENTAL PLAN OPTIONS		te at least 50% of the plan cost fo	or each employee or retiree who	
Are you adding, deleting or changing any dental products?		☐ Yes	□ No	
Are you adding, deleting or changing any dental products: Are you adding, deleting or changing any dental classes?		☐ Yes		
3. Are you adding, deleting or changing any dental contribution amounts/arrangemen		rangements?	□ No	
4. Are you making changes to the current continuation options for your employees?		oloyees?	☐ No	
f you selected "Yes" to questions 1, 2 or 3, p	olease fill out the informat	ion below.		
EMPLOY	ER CONTRIBUTION PERC	ENTAGE/AMOUNT		
Employee Class	Plan	Employer Contrib for Employee	ution Employer Contribution for Dependent	
			·	

Employer name:		Employer number:		
5. VISION PLAN OPTIONS				
 Are you adding, deleting or changing any vision products? Are you adding, deleting or changing any vision classes? Are you adding, deleting or changing any vision contribution amounts/arrangements? Are you making changes to the current continuation options for your employees? If you selected "Yes" to questions 1, 2 or 3, please fill out the information below. 		☐ Yes ☐ No		
EMPLOYER CONTRIBUTION PERCENTAGE/AMOUNT				
Employee Class 6. ANCILLARY PRODUCTS 1. Are you adding, deleting or changing any non-m ☐ Yes ☐ No If you selected "Yes," please fill out the informa		Employer Contribution Employer Contribution for Employee for Dependent asses or contribution amounts/arrangements?		
EMPLOYER	CONTRIBUTION PERCENTAGE/	AMOUNT		
Employee Class	Plan	Employer Contribution Employer Contribution for Employee for Dependent		

Employer name:	Employer number:
7. COMMENTS	
8. ACKNOWLEDGEMENTS	
-	nce Portability and Accountability Act (HIPAA) of 1996
protected health information (PHI) that the employer rece as required under HIPAA and other applicable laws, to no	er's authorized representative agrees to protect the confidentiality of eives from GuideStone® and from its employees and their dependents of use or disclose PHI other than permitted or required by GuideStone ent-related actions and decisions. The employer also agrees to make exprovisions of HIPAA and any other applicable laws.
Terms and Conditions o	f the Employer Adoption Agreement
	's authorized representative acknowledges that the employer has read
9. SIGNATURE	
Log into GuideStone Employer Access® Program (EAP) to a	ccess all of your renewal information.
EAP.GuideStone.org	
Authorized signature:	Date:
Please scan and email to InsuranceRenewal@GuideStone	e.org.
GUIDESTONE FINA	NCIAL RESOURCES USE ONLY
Yes No Employer requested that Group Plans m	ass move all employees from their existing medical/dental plan to:
Insurance Plans approval:	Date:
GP processed by:	Date: