DIOCESE *of* BAKER

Health & Life Insurance Enrollment Form

Last Name	First	MI	Date of Birth	Social Security Number

Home Address (Include City, State & Zip) | Phone Number

Email

Male ☐ Female ☐

Single ☐ Married ☐

WAIVER OF COVERAGE

I have decided not to apply for coverage offered.
This waiver does not apply to life insurance or weekly disability benefits.

Date: _____ Signature: _____

COVERAGE SELECTION

Medical, Dental, Vision

☐ Employee ☐ Emp/Spouse
☐ Emp/Child ☐ Family

Company Paid Life Insurance & Short Term Disability (Required)

Beneficiary Name: _____
Beneficiary SSN: _____
Beneficiary Relationship: _____

DEPENDENT INFORMATION

Eligible Dependents First, MI, Last Name	Address (Include City, State, Zip)	Sex	Date of Birth	Social Security Number	Full-Time College Student
Spouse:					
Child:					Y ☐ N ☐
Child:					Y ☐ N ☐
Child:					Y ☐ N ☐
Child:					Y ☐ N ☐

If more dependents, please list on a separate sheet and attach.

OTHER COVERAGE: In addition to this coverage, will anyone named on this application be covered by other insurance plans?
☐ Yes ☐ No If YES, please complete the information below.

Name of Insured	Effective Date of Policy	Medical or Dental	Single or Family	Covered Members

MEDICARE INFORMATION: Does anyone listed on this enrollment have Medicare coverage?
☐ Yes ☐ No If YES, please complete information below and attach a copy of the Medicare ID card

Name of person covered by Medicare	Effective Date of Policy	Part A or Part B?	Medicare eligibility due to over age 65, End-Stage Renal Disease or Total Disability?

(Continues on next page)

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OTHER COVERAGE QUESTIONNAIRE

Group Name: _____

Group Number: _____

Employee Name: _____
Last First M

Employee Unique ID: _____

Spouse's Name: _____
Last First M

Dependent Name(s): _____

_____

_____

Do any of the family members listed above have Medicare or are eligible for Medicare?

☐ NO ☐ YES (If yes, please complete the following.)

List the names of each covered individual _____

Effective Date of Coverage: Part A _____ Part B _____

Do any of the family members listed above have other group insurance currently in force?

☐ NO ☐ YES (If yes, please complete the following.)

List the names of each covered individual _____

_____

_____

Name of other insurance company _____

Group ID number _____ Effective Date of Coverage _____

Check all of the benefits provided under the other group plan:

☐ Medical ☐ Drug Card ☐ Dental ☐ Vision

I certify that the above statements are true and complete to the best of my knowledge.

Make sure to sign on the next page before submitting.

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ACCEPTANCE

I hereby enroll for coverage under my employer's Employee Benefit Plan and authorize my employer or successor to subtract the required deductions, if any, from my earnings. I understand that I am eligible to enroll for the types of coverage, as offered by my employer, listed in the above section noted COVERAGE SELECTION; however I do hereby knowingly and freely waive my eligibility in the WAIVER section. I further understand that I have the right to revoke this deduction authorization by executing a written revocation. I consent to and authorize any physician medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., Consumer Reporting Agency or other organization, institution or person that have any records to disclose to Benefit Plan Administrators my (or my minor children's) records relating to my (or my children's) identity, diagnosis, prognosis, or treatment. I understand that the specific type of information to be disclosed includes medical records and the purpose for this disclosure may be for application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation or for a legal investigation. I also understand that unless revoked in writing, this consent will remain in force for the period of time necessary to effectuate the purposes for which it was given. I know that I may request a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original.

Date: _____ Employee Signature: _____

EMPLOYER

Parish/School Name	Hire Date	Effective Date

Diocese of Baker			
	Hours per Week	Hourly Rate	Annual Salary

Date: _____ Authorized Signature: _____

IMPORTANT: PLEASE READ PRIOR TO ENROLLMENT

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may enroll yourself and certain dependents provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.