



# EMPLOYEE ENROLLMENT/CHANGE FORM



Return completed form to your business manager. See reverse side for important disclosures regarding declination of coverage

### APPLICATION BEING MADE FOR: HEALTH PLAN

(Check One):

- EMPLOYEE COVERAGE
- EMPLOYEE + SPOUSE COVERAGE
- EMPLOYEE + CHILD(REN) COVERAGE
- EMPLOYEE + FAMILY COVERAGE

### Plan Option Selection:

- Value Plan
- Premier Plan

### For completion by employer:

Application being made for:

- New employee coverage
- Special enrollee (attach proof)
- Late enrollee/open enrollment

EMPLOYEE NAME - LAST, FIRST, MIDDLE INITIAL		DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NO.	
HOME ADDRESS		CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER
SPOUSE ADDRESS (if different)		CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Date:		DIVISION (Circle One) 01 - PRIESTS    02 - LAY    03 - SEMINARIANS    04 - NUNS			
EMPLOYER: Roman Catholic Archdiocese of Atlanta			LOCATION NAME	EMAIL ADDRESS (optional)	

If you are adding a dependent, you may need to provide additional documentation to prove their eligibility.

PRINT NAMES OF DEPENDENTS APPLYING FOR COVERAGE: (LAST, FIRST)	SOCIAL SECURITY NUMBER	LEGAL RELATIONSHIP: SPOUSE, CHILD, STEP-CHILD, ETC	GENDER: (M / F)	INDICATE IF FULL-TIME COLLEGE STUDENT (IF YES, SEE BELOW)*	DATE OF BIRTH MO DAY YR

\*You will be required to provide proof of full-time student status upon receipt of a claim and on a regular basis in the form of a registrar's letter. Other documentation from the school that indicates full-time status and provides beginning/ending dates of the semester and has the dependent's name listed will be acceptable.

I hereby authorize any health plan, provider of health care services or their Business Associates who have any records, knowledge, or Protected Health Information of me or any family member for whom coverage is requested, to share the information with Corporate Benefit Services of America, Inc., and its Business Associates who provide services for the health plan described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members for the health plan. A photographic copy of this authorization shall be as valid as the original.

I hereby request the amount(s) and Benefits for which I am or may become eligible and hereby authorize my employer to deduct the required contributions, if any, from my earnings.

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning me or my dependents. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.

**X**

Sign your name, DO NOT PRINT OR TYPE \_\_\_\_\_ Date \_\_\_\_\_

Providing the above authorization makes it possible to determine your eligibility for enrollment in this health plan. As described in the Notice of Privacy Practices, you may revoke this authorization at any time as provided by applicable law and except to the extent that this authorization has been relied upon.

### FOR EMPLOYER USE ONLY

DIVISION # _____	LOCATION # _____	DATE OF FULL TIME EMPLOYMENT _____
EFFECTIVE DATE OF CHANGE / COVERAGE _____		ORIGINAL PART TIME HIRE DATE _____
		WHAT IS THE MINIMUM NUMBER OF HOURS WORKED PER WEEK? _____

Comments: \_\_\_\_\_

### FOR HOME OFFICE USE ONLY

<input type="checkbox"/> Timely	Prior Plan Credits	Group Number <b>10974</b>
<input type="checkbox"/> Late	Wait Start	
<input type="checkbox"/> Special	Cert Start _____	
<input type="checkbox"/> New	Cert End _____	
		Effective Date _____
		Account Rep _____

LF \_\_\_\_\_ MD \_\_\_\_\_ DI \_\_\_\_\_ DN \_\_\_\_\_ DL \_\_\_\_\_ OTH \_\_\_\_\_ VS \_\_\_\_\_ 24 \_\_\_\_\_ SAL \_\_\_\_\_ LTD \_\_\_\_\_ PPO \_\_\_\_\_

DEPT \_\_\_\_\_ LIFE2 \_\_\_\_\_ CV SUFFIX \_\_\_\_\_ COMMENTS: \_\_\_\_\_ RETURN TO REP: \_\_\_\_\_

## OTHER COVERAGE INFORMATION

This information you provide about other coverage will help us to coordinate benefits with any other group health plan you may have. Please provide the month, day and year for effective dates of coverage.

1. Will your dependents continue to be covered under another health insurance or dental plan while you are covered under this plan?  
 Yes  No
2. If yes, please answer the following:  
Medical  Yes  No      Dental  Yes  No
3. Name of policyholder \_\_\_\_\_ Date of birth \_\_\_\_\_
4. If this coverage is through your spouse's employer, please list the employer's name: \_\_\_\_\_  
If this is not through an employer, please list the source of other coverage: \_\_\_\_\_  
Name of medical insurance company \_\_\_\_\_ Telephone number \_\_\_\_\_  
Name of dental insurance company \_\_\_\_\_ Telephone number \_\_\_\_\_
5. Who will continue to be covered:     Spouse     Children
6. List names of covered persons: \_\_\_\_\_
7. Effective date of medical policy \_\_\_\_\_  
Type of plan:     Group     Individual     COBRA     Other  
Term date of medical policy \_\_\_\_\_ Effective date of dental policy \_\_\_\_\_  
Type of plan:     Group     Individual     COBRA     Other  
Term date of dental policy \_\_\_\_\_

## MEDICARE INFORMATION

- 1 Do your dependents currently have Medicare coverage?  Yes  No If yes, please answer the following:
- 2 If you or your spouse are retired, please supply the retirement date(s) \_\_\_\_\_
- 3 Name of person covered by Medicare \_\_\_\_\_ Medicare claim number \_\_\_\_\_
- 4 Is Medicare eligibility due to?  Overage 65  End-stage renal disease  Total Disability
- 5 Part A effective date \_\_\_\_\_ Part B effective date \_\_\_\_\_

## OTHER COVERAGE

1. Is there other coverage for your children due to a court decree?  Yes  No  
If yes, name of parent(s) with legal custody of children: \_\_\_\_\_  
Address of parent(s) with legal custody: \_\_\_\_\_  
Is there a court order making the non-custodial parent responsible for the child(ren)'s medical/dental expenses?  
 Yes  No  
If yes, please supply a copy of the legal documentation for this decision.  
Failure to provide this information will result in denial of claims submitted for you or your family members.

Employee Name	Social Security Number
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**DECLINATION OF ENROLLMENT IMPORTANT!** If you are waiving your dependents' right to coverage under this plan, you must declare the reason for declination in writing below. Failure to declare your reasons for waiving coverage may limit your opportunity to join the plan later and could result in denial of claims for pre-existing conditions.

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected not to participate in each of the categories checked below:

Effective Date of Declination \_\_\_\_\_

**Health Plan**

- SPOUSE
- CHILD(REN)

List names of dependent to be declined:

REASON FOR REFUSAL OF MEDICAL COVERAGE:

- Have coverage under another plan. Name of Other Plan \_\_\_\_\_  
Indicate who is currently covered under other plan(s):  Spouse  Children
- Other. Give Explanation \_\_\_\_\_

Failure to specify that you are declining coverage because your spouse and/or children have other coverage may waive your special enrollment rights as described above.

I understand that by not applying for the coverage above, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed.

**X**

Sign your name, DO NOT PRINT OR TYPE \_\_\_\_\_ Date \_\_\_\_\_

**PORTABILITY CREDITS:**

In certain instances, benefits may not be payable for pre-existing conditions (illnesses or injuries for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage). If a pre-existing provision applies, each participant has the right to prove prior creditable coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan(s).

The pre-existing exclusion period may be reduced by the number of days you were covered under a qualifying prior health plan, provided there is not a gap of sixty-three (63) days or more. Please review pre-existing condition limitations in your summary plan description.

- Certification form(s) are attached.
- Certification form(s) will be forwarded when received from prior benefit plans.
- I did not have health insurance coverage prior to this plan, nor did my dependents.

It is not the responsibility of Meritain Health or your employer to obtain a Certificate on your behalf. It is the employee's responsibility to obtain the Certificate and submit a copy to his/her employer.