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 ☐MALE ☐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
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed Date:

DIVISION (Circle One)
01 - PRIESTS 02 - LAY 03 – SEMINARIANS 04 - RELIGIOUS

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 MERITAIN HEALTH USE ONLY

☐ Timely Prior Plan Credits
☐ Late Wait Start Group Number 10974
☐ Special Cert Start ______ Effective Date
☐ New Cert End 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 be used 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 covered by this plan?
   Medical ❑ Yes ❑ No   Dental ❑ Yes ❑ No
   If yes, please answer the following:
   a. Name of policy holder ______________________ Date of birth ______________________
   b. If this coverage is through your spouse's employer, please list the employer's name: ______________________
   c. 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 ______________________
   d. Who will continue to be covered: ❑ Spouse ❑ Children
      List names of covered persons:______________________
   e. Effective date of medical policy ______________ Type of plan: ❑ Group ❑ Individual ❑ COBRA ❑ Other
   f. Term date of medical policy ______________
   g. Effective date of dental policy ______________ Type of plan: ❑ Group ❑ Individual ❑ COBRA ❑ Other
   h. Term date of dental policy ______________

MEDICARE INFORMATION

1. Do your dependents currently have Medicare coverage? ❑ Yes ❑ No
   (If yes, please answer the following:)

a. If you or your spouse are retired, please supply the retirement date(s) ______________________
b. Name of person covered by Medicare ______________________ Medicare claim number ______________________
c. Medicare eligibility is due to: ❑ Overage 65 ❑ End-stage renal disease ❑ Total Disability
d. 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.

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.

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 ______________________ ☐ SPOUSE ☐ CHILD(REN)
List names of dependents 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