

Roman Catholic Diocese of Owensboro Benefit Plan

Enrollment / Change Form

Employer _____ Location # _____

Employee: Last name _____ First name _____ M.I. _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zipcode _____ Sex: Male _____ Female _____

_____ / _____ / _____ Medical/dental coverage begins on the first day of the first full month after date of hire.
Date of Hire

Type of plan: Single Family Waive coverage

Medical/dental coverage choice: \$500 deductible \$2,000 deductible

Do you have other medical or medicare coverage this insurance will coordinate? Yes No

If yes, name of plan _____

Family Information: Complete this section only if family coverage is chosen. Dependents must be eligible for coverage under the terms of the Plan. To expedite enrollment for those dependents over the age of 18 submit "Proof of Current Enrollment" from the educational institution they attend.

Sex: _____
1) _____ M F _____ / _____ / _____
Spouse Name Date of Birth Social Security #
Add-date _____ / _____ / _____ Term-date _____ / _____ / _____ Other coverage? Yes No

2) _____ M F _____ / _____ / _____
Child Name Date of Birth Social Security #
Add-date _____ / _____ / _____ Term-date _____ / _____ / _____ Yes No
Full-time student Name of Educational Institution

3) _____ M F _____ / _____ / _____
Child Name Date of Birth Social Security #
Add-date _____ / _____ / _____ Term-date _____ / _____ / _____ Yes No
Full-time student Name of Educational Institution

4) _____ M F _____ / _____ / _____
Child Name Date of Birth Social Security #
Add-date _____ / _____ / _____ Term-date _____ / _____ / _____ Yes No
Full-time student Name of Educational Institution

**Attach supplemental sheet for additional family members

Continued on back →

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize any doctor, hospital, insurance company, employer or organization to release any information regarding history, treatment, disability, or benefits for claims to Roman Catholic Bishop of Owensboro Employee Benefit Plan. A copy of this authorization shall be valid as the original. **I UNDERSTAND THE FOLLOWING:** This form will be used for benefit information and as claim form. The information listed above is correct and true. To verify incorrect information for this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution to the cost of the benefits I have selected. If I am declining enrollment for myself or my family because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 30 days after that event. Please be advised that this plan contains a pre-existing exclusion for health care services. The exclusion lasts 12 months from your effective date of providing proof of prior health care coverage. You should have received a "Certificate of Health Care Coverage" from your previous health plan or employer.

Employee Signature (Must be signed by employee to be valid)	/ /
	Date signed

CREDITABLE COVERAGE: (Applies to new enrollments only)

If you are coming to this plan from another insurance plan, make sure to send the "Proof of Creditable Coverage" form from your previous plan. In certain instances, benefit 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 creditable coverage, including the right to secure a certificate from a prior plan of coverage. It is your responsibility to request a "Proof of Creditable Coverage" form from your prior plan. Attach all certification forms verifying prior health plan coverage dating up to 12 months prior to this application.

I am coming into this plan with medical/dental coverage up to the effective date of this plan Yes No

Proof of Creditable Coverage form(s) are attached

Proof of Creditable Coverage form(s) will be forwarded when received from prior benefit plan(s)

For Employer Use only:

Check the box(es) that apply:

New employee _____ / _____ / _____ (First day of active employment) Date

Enrollment change _____ / _____ / _____ (Date change takes effect)

Name/address change Dependent change

Termination _____ / _____ / _____

Retirement _____ / _____ / _____

Location transfer From location # _____ To # _____

No. hours worked each week: _____ Occupation/Title: _____

Class: Lay Religious Priest Medicare coverage: Primary Secondary

Earnings: Annual amount \$ _____ (Determines lay employees Life and LTD benefit)

Verified by: _____ Date: _____ / _____ / _____

- 1) Send copy to - BAS, Inc., P.O. Box 6121, Bluefield, WV 24701
- 2) Keep copy in employee file
- 3) Send copy to - Diocese of Owensboro, ATTN: Kay Hardin, 600 Locust Street, Owensboro, KY 42301

