ARCHDIOCESE OF NEW YORK

UnitedHealthcare

For More Information, Please Visit
www.myuhc.com

MEDICAL BENEFIT PLAN ENROLLMENT & CHANGE FORM

Note: Return your completed form to your Local Benefits Administrator within 30 calendar days of the date of enrollment, a life event, date of any change(s). Failure to do so may result in loss of coverage.

Annual Salary (Administrator Use Only)	Effective Date of Coverage or Change Month/Day/Year
$_____	/ /

Please indicate the reason you are completing this form:

❑ New Hire ❑ Open Enrollment ❑ Waive Coverage ❑ Marital/Dependent Status Change ❑ Dependent Enrollment ❑ Medicare Enrollment
❑ Retirement ❑ Work Hours Change ❑ Update Salary ❑ Name Change ❑ Address Change
❑ Qualified Life Event _____ ❑ Other _____

Last Name_____ First Name_____ MI____ Social Sec. #: _____-_____-_____

Date of Birth_____/_____/_____ Gender: ❑ Male ❑ Female Home Address_____ Apt. No._____

City_____ State_____ Zip_____ Home Phone_____Work Phone_____

Status ❑ Active ❑ Retired Occupation_____ Covered by Collective Bargaining Agreement: ❑ Yes ❑ No Date of Hire____/____/_____

❑ Part/Time Employee ❑ Full/Time Employee Regular Weekly Work Hours_____ Marital Status: ❑ Single ❑ Married Marriage Date ____/____/_____ ❑ Divorced ❑ Widowed

MEDICAL PLAN ELECTION

Select from the following coverage options for the Plan Year

Type of Medical Coverage ❑ Single ❑ Two Person ❑ Family ❑ Medicare Supplement ❑ Waive Medical Coverage

Payroll contribution Election: I have elected to withhold from my paycheck on the following basis: ❑ Pre-Tax ❑ Post-Tax

DEPENDENT INFORMATION

List below your name and the name(s) of eligible dependent(s) to be covered, your spouse and dependent children. A child will be considered a dependent until the end of the month in which they reach age 26 (the child cannot be covered under Medicaid/Medicare). A Continuation of Coverage enrollment form will automatically be mailed to the dependent child. The dependent child can elect to extend group medical coverage through the end of the month in which they reach age 29 by completing the continuation of coverage enrollment form and submit premium payments.
Disabled Child: To apply for extension of coverage for a disabled child before the child reaches the limiting age, obtain the *Statement for Eligibility Beyond Limiting Age in the Plan Due to Disability Form from the Benefit Office.*

First Name of Dependent (Include Last Name if Different from Yours)	Sex M/F	Date of Birth Mo./Day/Yr.	Relationship to Employee	Social Security Number	Full Time Student? Yes/No	Disabled? Yes/No	Marriage Certificate (For spouse)	Birth Certificate (For children)
			SELF					

OTHER MEDICAL COVERAGE

Are you a dependent/or spouse covered by another health plan? ❑ Yes ❑ No

If "Yes", please complete this section: Name and address of other insurance carrier: _____ Policy Number_____

Other Insurance Carrier Phone #: _____ Primary Named Insured_____ Person(s) Covered: ❑ Self ❑ Spouse ❑ Child(ren)

Policyholder_____ Address_____

Employer_____ Address_____ Phone_____

MEDICARE INFORMATION

If this election form includes a person with Medicare coverage, complete the following (Attach a copy of your red, white and blue Medicare card):

Name of Medicare Eligible Person	Hospital (Part A) Effective Date	Medical (Part B) Effective Date	Medicare Identification #	HIB Suffix

VISION CARE - CLERGY AND RELIGIOUS ONLY

Clergy: ❑ Yes ❑ No Coverage Religious: ❑ Yes ❑ No Coverage (Coverage is mandatory for Religious on stipend)

VISION CARE – LEGACY PLAN – ST. RAYMOND'S CEMETERY (NON-BARGAINING) AND TRUSTEES OF ST. PATRICK

Type of Coverage: ❑ Single ❑ Two Person ❑ Family ❑ Waive Vision Coverage

My signature below affirms eligibility for coverage, and authorization to deduct any contribution from my paycheck. All information provided is complete and true to the best of my knowledge. Any person who knowingly and with intent to defraud, submits an application for health benefits or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which subjects such person to civil penalties. If retired or otherwise not actively at work, I agree to pay the applicable premium required or portion thereof within 30 calendar days of the premium due date.

Employee/Participant Signature (Required): _____Date: _____

Employee/Participant Print Name (Required): _____

EMPLOYER INFORMATION

Institution Name _____ Institution/Department #_____/_____ Division Code_____

Address _____ City_____ State_____ Zip Code_____ Phone_____ _____

Employer's Signature (Required): _____ Date_____

Employer Print Name (Required): _____