ARCHDIOCESE of NEW YORK

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 ❑Other _____

Specify Change

MEMBER INFORMATION

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

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.

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*
			SELF			

EMPLOYER INFORMATION

Employer *(Institution)*_____ Institution No._____ Division Code_____

Employer Street Address _____ City_____

State_____ Zip Code_____ Phone_____

IMPORTANT

FORM CONTINUES ON THE REVERSE SIDE

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 elect that the employee contributions for the coverage I have selected be subtracted from my paycheck on the following basis:

❑Pre-Tax ❑Post-Tax ❑N/A

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_____
Association *(if applicable)* _____ Address_____ Phone_____
Effective Date_____/_____/_____ Plan Type: ❑Hospital ❑Medical ❑**Major** Medical ❑**Extended** Medical

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)*

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 an application of 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 : _____

Employer's Signature *(Required)*: _____ Date: _____

Employer Print Name *(Required):* _____

Administrators: Mail completed form to – Employee Benefit Connections, 1011 First Avenue, Suite 1654, New York, New York 10022 or Fax form to 212.644.0690