

**CATHOLIC DIOCESE OF EL PASO  
BENEFITS ENROLLMENT FORM**



- New Enrollment
- Change of Status
- Termination Date \_\_\_\_\_

Group Name **Diocese of El Paso Health Plan**  
 Employee Hire Date \_\_\_\_\_  
 Benefits Effective Date \_\_\_\_\_

<b>A. EMPLOYEE INFORMATION</b>			
Name (Last, First, Middle)		Sex	Marital Status
Social Security Number	Date of Birth	Phone Number	
Employee Address	City	State	Zip Code
			Diocesan Entity

<b>B. BENEFITS ENROLLMENT</b>			
<input type="checkbox"/> I Choose to Accept Medical/Dental/Vision Coverage and Basic Life and AD&D _____ Employee Only    _____ Employee/Spouse    _____ Employee/Child(ren)    _____ Employee/Family			
<input type="checkbox"/> I Choose to Decline <input type="checkbox"/> Medical/Dental/Vision Coverage <input type="checkbox"/> Basic Life and AD&D			
<input type="checkbox"/> I Choose to <b>Accept</b> Section 125 Salary Deferral ** (Pre - Tax Deduction) <input type="checkbox"/> I Choose to <b>Decline</b> Section 125 Salary Deferral (Deduction after taxes)			

<b>C. COVERED DEPENDENTS</b>			
Name (Last, First, MI)	Relationship	Date of Birth (mmddyyyy)	Social Security No.

<b>D. LIFE INSURANCE</b>			
<input type="checkbox"/> Basic Life and AD&D \$ _____ <input type="checkbox"/> Optional Life \$ _____ <input type="checkbox"/> Dependent Life---Spouse \$ _____    Child(ren) \$ _____			
Beneficiary: (Name) _____		Relationship _____	

<b>E. OTHER COVERAGE INFORMATION</b>			
Are you or any dependents covered by any other health coverage? <b>YES / NO</b> (If <b>YES</b> please complete this section)			
Type of coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare <b>A B</b> (please circle)			
Insured Name _____		Date of Birth _____	Effective date of Coverage _____
Name of Other Health Carrier _____		Group/Policy No. _____	
Name of Covered Dependent(s) _____			

<b>F. COVERAGE CANCELLATION</b>			
Coverage Being Cancelled: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Life Insurance and AD&D			
Reason for Cancellation: _____			
Covered Dependents _____			

<b>G. MEDICAL RECORDS RELEASE</b>	
I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity to give the Company, upon request any information covering the health condition of any person included under the coverage(s) whenever the information is considered necessary by the company for proper disposition of the Application or of a claim submitted for payment.	
Applicant's Signature _____	Date _____

<b>H. EMPLOYEE AUTHORIZATION **</b>	
I hereby apply for Benefits for which I am eligible and I authorize the appropriate contributions, if any, be deducted from my earnings. <b>** I understand by choosing section 125 salary deferral that no changes can be made until an annual open enrollment date, unless I have a qualifying family status change. At which time I will have 31 days from the date of the event to make changes/additions/deletions to my benefit election (i.e. marriage, divorce, birth/adoption of a child, loss of spousal coverage, loss/reduction of income, child reaches maximum benefit age, death of spouse or dependent currently covered) list is not all inclusive.</b>	
Applicant's Signature _____	Date _____

Job Title: \_\_\_\_\_  
 Annual Salary: \_\_\_\_\_