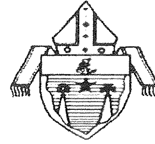
If enrolling for Medical Benefits

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 07-01-10

A. EMPLOYEE INFORMATION

Name (Last, First, Middle)			Sex	Marital Status
Social Security Number	Date of Birth	Phone Number		
Employee Address	City State	Zip Code	Diocesan Entity Name of Parish School or Entity	

B. BENEFITS ENROLLMENT

☒ I Choose to Accept Medical/Dental/Vision Coverage and Basic Life and AD&D
______Employee Only ______Employee/Spouse ______Employee/Child(ren) ______Employee/Family (Mark One)
☐ I Choose to Decline ☐ Medical/Dental/Vision Coverage ☐ Basic Life and AD&D
☐ I Choose to **Accept** Section 125 Salary Deferral ** (Pre - Tax Deduction) ☐ I Choose to **Decline** Section 125 Salary Deferral (Deduction after taxes)
← choose (1) or the other →

C. COVERED DEPENDENTS

Name (Last, First, MI)	Relationship	Date of Birth (mmddyyyy)	Social Security No.
Only if enrolling dependents			

D. LIFE INSURANCE

☒ Basic Life and AD&D $20,000 ☐ Optional Life $__________ ☐ Dependent Life---Spouse $____________ Child(ren) $____________
Beneficiary: (Name)______________________________ **Relationship**______________
If more than one (1) beneficiary, fill out Met-Life form

E. OTHER COVERAGE INFORMATION

Are you or any dependents covered by any other health coverage? **YES / NO** (If **YES** please complete this section) * Mark "Yes" if those enrolled on this plan are covered elsewhere, otherwise "No"
Type of coverage ☐ Medical ☐ Dental ☐ Vision ☐ Medicare **A 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)______________________________

F. COVERAGE CANCELLATION

Coverage Being Cancelled: ☐ Medical/Dental ☐ Life Insurance and AD&D
Reason for Cancellation:______________________________
Covered Dependents______________________________

G. MEDICAL RECORDS RELEASE

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____________

H. EMPLOYEE AUTHORIZATION **

I hereby apply for Benefits for which I am eligible and I authorize the appropriate contributions, if any, be deducted from my earnings. ** **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.**

Applicant's Signature______________________________ Date________

Job Title: ______________________________
Annual Salary: ______________________________