

*IF declining 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 <i>Name of Parish School or Entity</i>

**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

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)

C. COVERED DEPENDENTS			
Name (Last, First, MI)	Relationship	Date of Birth (mmdyyyy)	Social Security No.

**D. LIFE INSURANCE**

Basic Life and AD&D \$ 2000     Optional Life \$ \_\_\_\_\_     Dependent Life---Spouse \$ \_\_\_\_\_    Child(ren) \$ \_\_\_\_\_

Beneficiary: (Name) \_\_\_\_\_ Relationship \_\_\_\_\_

*if more than one beneficiary, fill out Net-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)

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: \_\_\_\_\_