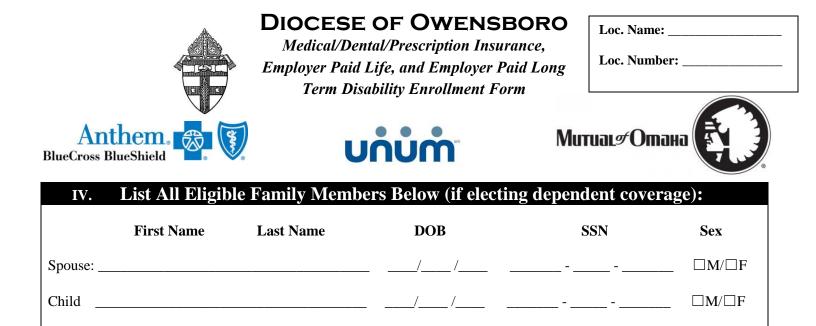
	DIOCESE OF OV Medical/Dental/Prescrip Employer Paid Life, and E Term Disability Enro	ption Insurance, mployer Paid Long	Loc. Name:
Anthem. Reference of the second secon	บทบ่ท	Mu	тиася Отана
I. Employee Inform	mation (please print clea	arly):	
Social Security Number:		Date of Hire:/	_/
Name:			
(First)	(Middle)	(Last))
Date of Birth://	Ν	Male: 🗆 Female: 🗆	
Address:			
(Street)	(City)	(State)	(Zip)
deductions from my payche which requires my contribu- unless I have a qualifying ev <u>I decline</u> Medical and De please go to the second page	Plan allows eligible employee iums before taxes. Medical, d the date of hire. Employees a Caremark for Prescription C <u>he Section 125 Health Plan an</u> eck necessary to cover the pre- tion under the Section 125 Play vent per Section 125 of the IR ental coverage in the Health F e and sign and date the form.	lental and prescription of will receive an Anthem Coverage. <u>Ind I authorize</u> the Dioce miums for the coverage an. I understand that I of RS Code (please Plan (please initia	coverage begins on the first a card for medical/dental ese of Owensboro to make e which I have elected and cannot change my election e initial)
III. Check the Approx	opriate Boxes		
□Employee Only □Employee + Family	□New Hire □Change of	Reason for change in a Termination Marriage	status: □Other Insurance □Death
	Enrollment Status	□Newborn Child	

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AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize any doctor, hospital, insurance company,
employer or organization to release any information regarding history, treatment, disability, or benefits for claims to Roman Catholic
Bishop of Owensboro Employee Benefit Plan. A copy of this authorization shall be valid as the original.
I UNDERSTAND THE FOLLOWING: This form will be used for benefit information and as a claim form. The information listed
is correct and true. To verify incorrect information for this form is to commit fraud that may be punishable under law. This form will
be used as an authorization to deduct from my pay my contribution to the cost of the benefits I have selected. If I am declining
enrollment for myself or my family because of other group health coverage, I may, in the future, be able to enroll myself or my
dependents in this plan. I must request enrollment within 21 days after that event. In addition, if I have a new dependent as a result of

dependents in this plan. I must request enrollment within 31 days after that event. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after the event.

Do you have other Medical Insurance or Medicare cov	erage?	\Box Yes	\Box No	

Child: ______- - ____ - _____

If yes, name of plan/carrier and effective date of coverage: _____

I work 20 hours or more per week: □Yes* \square No

Child: / /

Child: _____/___/___

Employees working 20 hours or more per work week are eligible for full time benefits. This Benefit Enrollment form will enroll employees in the Medical/Dental/Prescription Insurance as well as the employer paid Basic Life Insurance, Long Term Disability and Accidental Death and Dismemberment Insurance.

Please return this form to the person responsible for collecting the health insurance enrollment forms at your location.

Employee Signature: ______ *Date:* ____/____

- -

_____-

 $\Box M / \Box F$

 $\Box M / \Box F$

 $\Box M / \Box F$

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DIOCESE OF OWENSBORO

Medical/Dental/Prescription Insurance, Employer Paid Life, and Employer Paid Long Term Disability Enrollment Form



5	Loc. Name:
g	Loc. Number:
Мит	иас#Отана

Enter code that applies: _____

This page for EMPLOYER USE only:

Check the her (eg) that apply
Check the box(es) that apply:
1. New employee
2. Enrollment change (Date change takes effect.) Qualifying Event:
3. Name/address change Dependent change Effective Date:/
4. Termination Date:/ Last coverage date:/
5. Retirement Date:/ Last coverage date:/
6. Location transfer From location # to # Effective Date:/
Class:
Lay Religious Priest Medicare coverage: Primary Secondary
No. hours worked each week: Occupation/Title:
Earnings:
Annual amount \$ (Determines lay employee's Life and LTD benefits.)
Employer Signature:
Date Signed: / Phone #: ()
1) Send copy to BAS, Inc., P. O. Box 896, Bluefield WV 24701
2) Keep copy in employee file 3) Sand copy to Diagase of Owenshare ATTN: Mary Hall 600 Locust St. Owenshare, KY 42201
3) Send copy to –Diocese of Owensboro, ATTN: Mary Hall, 600 Locust St, Owensboro, KY 42301