Diocese of Owensboro

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

Loc. Name: _____

Loc. Number: _____

Anthem BlueCross BlueShield

UNUM

Mutual of Omaha

I. Employee Information (please print clearly):

Social Security Number: _____ - _____ - _____ Date of Hire: ____/____ /____

Name:_____
(First) (Middle) (Last)

Date of Birth: ____/____ /____ Male: ◯ Female: ◯

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

II. Medical and Dental Insurance

Enrollment in the Section 125 Plan allows eligible employees to reduce their taxable income by withholding certain qualifying benefit premiums before taxes. Medical, dental and prescription coverage begins on the first day of the first full month after the date of hire. Employees will receive an Anthem card for medical/dental benefits and a second card from Caremark for Prescription Coverage.

Check one of the following:

☐ I elect to participate in the Section 125 Health Plan and I authorize the Diocese of Owensboro to make deductions from my paycheck necessary to cover the premiums for the coverage which I have elected and which requires my contribution under the Section 125 Plan. I understand that I cannot change my election unless I have a qualifying event per Section 125 of the IRS Code. _____. (please initial)

☐ I decline Medical and Dental coverage in the Health Plan ____. (please initial) If declining coverage please go to the second page and sign and date the form.

III. Check the Appropriate Boxes

☐ Employee Only ☐ Employee + Family	☐ New Hire ☐ Change of Enrollment Status ☐ Open Enrollment	**Reason for change in status:** ☐ Termination ☐ Other Insurance ☐ Marriage ☐ Death ☐ Newborn Child ☐ Divorce ☐ Last Name/Address Change ☐ Retirement ☐ Adoption/Legal Custody of Child ☐ Legal Custody of Parent ☐ Dependent Child Married/Reached Age Limit ☐ Loss of Health Insurance
☐ $500 Deductible ☐ $2,000 Deductible		

Diocese of Owensboro

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

Loc. Name: _____

Loc. Number: _____

Anthem BlueCross BlueShield

UNUM

Mutual of Omaha

IV. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	DOB	SSN	Sex
Spouse:			____/____/____	_____ - _____ - _____	☐M/☐F
Child			____/____/____	_____ - _____ - _____	☐M/☐F
Child:			____/____/____	_____ - _____ - _____	☐M/☐F
Child:			____/____/____	_____ - _____ - _____	☐M/☐F
Child:			____/____/____	_____ - _____ - _____	☐M/☐F

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 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 coverage? ☐Yes ☐No

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

I work 20 hours or more per week: ☐Yes* ☐No

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:*** ____/____/____

DIOCESE OF OWENSBORO

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

Loc. Name: _____

Loc. Number: _____

Anthem BlueCross BlueShield

UNUM

Mutual of Omaha

Enter code that applies: _____

This page for EMPLOYER USE only:

Check the box(es) that apply:
1. New employee ☐ _____/_____/_____ (First day of active employment.) Start coverage date: _____/_____/_____
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: _____ Title: _____

Date Signed: _____/_____/_____ Phone #: (_____) _____ - _____

1) Send copy to BAS, Inc., P. O. Box 896, Bluefield WV 24701
2) Keep copy in employee file
3) Send copy to –Diocese of Owensboro, ATTN: Mary Hall, 600 Locust St, Owensboro, KY 42301