ACCB Alaska Conference of Catholic Bishops – Insurance Division

Employee Benefits ENROLLMENT / CHANGE FORM

This form can be used as an initial enrollment or to report a change in information. Please complete all information by printing clearly and firmly or by typing. If additional space is needed, please attach a statement with the appropriate information. Please check the applicable boxes below.

I. Location Name **Term Date:**

☐ New Enrollment ☐ Re-Enroll ☐ Waiver ☐ Change ☐ Transfer from Location # _____ to # _____ ☐ Extended Benefits ☐ Terminate

II. EMPLOYEE INFORMATION ☐ LAY EMPLOYEE ☐ DIOCESAN PRIEST ☐ OTHER _____

LAST NAME	FIRST	MI	SOC. SEC. NO.

STREET ADDRESS	CITY	STATE	ZIP

DATE OF HIRE	DATE FULL TIME	OCCUPATION	ANNUAL SALARY	HOURS WORKED PER WEEK	EMPLOYEE EMAIL:

DATE OF BIRTH	SEX	MARITAL STATUS	Home Phone (including area code)	CELL PHONE (Including area code)
			( )	( )

III. DEPENDENT INFORMATION (Required if dependent coverage is to be added or changed)

FULL NAME (Including middle initial)	SOC. SEC. NO.	SEX (M/F)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE	Medical (X)	Dental (X)	Vision (X)
SPOUSE							
DEPENDENT #1							
DEPENDENT #2							
DEPENDENT #3							

IV. EMPLOYEE COVERAGE ELECTION ☐ LAY MEDICAL Default ☐ LAY MEDICAL "Buy-up" ☐ DENTAL ☐ VISION

☐ SEMINARIAN MEDICAL ☐ PRIEST MEDICAL ☐ NONE**, COMPLETE WAIVER SECTION**

V. LIFE/AD&D & LTD INSURANCE COVERAGES – Eligible employees are automatically enrolled in the Basic Life and AD&D Plan, sponsored by ACCB.

NAME OF PRIMARY BENEFICARY	ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP	DATE OF BIRTH
NAME OF CONTINGENT BENEFICARY	ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP	DATE OF BIRTH

NOTE: If you require additional space for additional Dependents or Contingent Beneficiaries, please attach separate sheets

PLEASE READ SECTIONS VI. & VII. CAREFULLY (if waiving coverage-please sign both!)

VI. RELEASE and APPLICATION SIGNATURE:

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document, that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs when in excess of the amounts payable under the plan.

I also authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give the health plan, respective agents or representatives any and all information or records relating to health history, health examinations, services rendered, or treatment given including treatment for alcohol, substance abuse or mental or emotional disorders, A.I.D.S., or A.R.C. of me or any of my dependents applying for coverage or of any claim for benefits.

I also authorize the health plan to disclose all such health or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits. If my coverage is under a master policy held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure of them for the purpose of administering my coverage, utilization review or financial audit.

This authorization is effective immediately and shall remain in effect for use in connection with any claim for benefits for as long as any health coverage may be in effect. A photocopy of this authorization is as valid as the original.

I HAVE READ AND UNDERSTOOD SECTION VI – **APPLICANT SIGNATURE** X _____ DATE _____

VII. WAIVER of COVERAGES

The current benefits have been explained to me thoroughly. **I DO NOT wish to enroll in the following coverage(s)** ☐ ENROLLEE : ☐ MEDICAL ☐ DENTAL ☐ VISION

☐ DEPENDENT: ☐ MEDICAL ☐ DENTAL ☐ VISION

Is the coverage being waived due to coverage by another health plan? ☐ YES ☐ NO
I understand that by waiving the coverage above, I will not be entitled to any benefits provided by the plan.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO SECTIONS VI AND THE TERMS OF THIS ENROLLMENT FORM.

WAIVER OF COVERAGE SIGNATURE X _____ DATE _____

TO BE COMPLETED BY LOCATION ADMINISTRATOR ONLY					EFFECTIVE DATE

VIII. REASON FOR THE CANCELLATION / CHANGE

EMPLOYEE COVERAGE:

☐ Discharged ☐ Deceased: Date _____ ☐ Last day worked: _____ ☐ Retirement: Date_____ ☐ Resignation: Date_____
☐ Date of disability: _____ ☐ Reduction of work hours ☐ New dependent (Spouse or Child) ☐ New name:_____
☐ Increase of work hours ☐ New address ☐ Other please specify: _____

DEPENDENT COVERAGE:

☐ Death of covered employee ☐ Date of divorce / legal separation _____ ☐ Eligible for Medicare
☐ No longer an eligible dependent ☐ Termination of dependent's health coverage

LOCATION ADMINISTRATOR NAME	SIGNATURE	DATE

File Location: Finance/AOA Health Ins/FY 2016/ Enrollment Package