

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:
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-Enroll <input type="checkbox"/> Waiver <input type="checkbox"/> Change <input type="checkbox"/> Transfer from Location _____ to _____ <input type="checkbox"/> Extended Benefits <input type="checkbox"/> Terminate						
II. EMPLOYEE INFORMATION						
<input type="checkbox"/> LAY EMPLOYEE <input type="checkbox"/> DIOCESAN PRIEST <input type="checkbox"/> 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						
<input type="checkbox"/> LAY MEDICAL Default <input type="checkbox"/> LAY MEDICAL "Buy-up" <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> SEMINARIAN MEDICAL <input type="checkbox"/> PRIEST MEDICAL <input type="checkbox"/> NONE- COMPLETE WAIVER SECTION VII						
V. LIFE/AD&D & LTD INSURANCE COVERAGES – Eligible employees are automatically enrolled in the Basic Life and AD&D Plan, sponsored by ACCB. This coverage cannot be waived. A separate form must be completed, designating a beneficiary of this benefit.						
VI. RELEASE and APPLICATION SIGNATURE: PLEASE READ SECTIONS VI. & VII. CAREFULLY (if waiving coverage, please <u>sign both!</u>)						
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>I HAVE READ AND UNDERSTOOD SECTION VI – EMPLOYEE SIGNATURE X _____ DATE _____</p>						
VII. WAIVER of COVERAGES (Note that <u>both</u> sections VI and VII must be signed if waiving coverage)						
The current benefits have been explained to me thoroughly. I DO NOT wish to enroll in the following coverage(s) <input type="checkbox"/> ENROLLEE : <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> DEPENDENT: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION						
Is the coverage being waived due to coverage by another health plan? <input type="checkbox"/> YES <input type="checkbox"/> 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:						
<input type="checkbox"/> Discharged <input type="checkbox"/> Deceased: Date _____ <input type="checkbox"/> Last day worked: _____ <input type="checkbox"/> Retirement: Date _____ <input type="checkbox"/> Resignation: Date _____ <input type="checkbox"/> Date of disability: _____ <input type="checkbox"/> Reduction of work hours <input type="checkbox"/> New dependent (Spouse or Child) <input type="checkbox"/> New name: _____ <input type="checkbox"/> Increase of work hours <input type="checkbox"/> New address <input type="checkbox"/> Other please specify: _____						
DEPENDENT COVERAGE:						
<input type="checkbox"/> Death of covered employee <input type="checkbox"/> Date of divorce / legal separation _____ <input type="checkbox"/> Eligible for Medicare <input type="checkbox"/> No longer an eligible dependent <input type="checkbox"/> Termination of dependent's health coverage						
LOCATION ADMINISTRATOR NAME		SIGNATURE			DATE	