Custom Benefit Administrators

GROUP ENROLLMENT FORM

CBA Use Only
Effective Date: _____

Parish/Institution Catholic Charities of the Diocese of La Crosse Inc. **Dept.** 0010 **Group #** 8201

Last Name | First Name | MI | Date of Birth | Sex

Street Address | Social Security No.

City | State | Zip | First Date of Work

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Job Title | Hours per Week | Home Phone Number

BENEFITS REQUESTED:

* **HealthEOS PPO only available if residing outside of Health Tradition PPO service area**
Health Tradition - La Crosse plus southern & eastern locations **(call to confirm PPO, if needed)**
HealthEOS - Eau Claire, Wisconsin Rapids & Stevens Point area plus northern locations

MEDICAL ____ Single ____ Family

Deductible: ____ $1,000 ____ HSA-Qualified
(Single-$2,000 / Family-$2,600 individual, $4,000 family)

PPO Request: ____ Health Tradition ____ HealthEOS (See above)

DEPENDENTS: Please only list dependents to be covered under this plan. (Include last name if different from employee's.)

Name of Dependent	Date of Birth	Sex	Social Security No.	If over age 19, full-time student?*
Spouse	/ /		/ /	
Child	/ /		/ /	Yes / No
Child	/ /		/ /	Yes / No
Child	/ /		/ /	Yes / No
Child	/ /		/ /	Yes / No
Child	/ /		/ /	Yes / No

OTHER INSURANCE COVERAGE: As of your effective date, will there be any other medical insurance in effect on you or any dependents to be covered?
YES ____ NO ____

If Yes, other insurance coverage is: Single ____ Family ____

If Yes, primary insured name: _____ Carrier Name: _____

Family Members covered under other insurance: _____

WAIVER OF BENEFITS (Must sign below even if waiving coverage)

I, the undersigned, an employee of the above named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

____ Single Medical ____ Family Medical

Reason for waiving coverage: _____

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION

I enroll for the benefits I indicated in the BENEFITS REQUESTED section which will be provided by the group plan I am eligible for. I authorize deductions from my earnings if required. I have the right to revoke this deduction authorization, as permitted under any Section 125 plan in place by my employer (if applicable), if I do so in writing on forms required by such plans. I refuse the benefits I indicated in the WAIVER OF BENEFITS section.

I authorize any physician, medical or dental practitioner, hospital, clinic, other medical related facility, insurance or reinsurance company, having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of myself, my spouse or my minor children and any non-medical information on myself, my spouse or my minor children to give to Custom Benefit Administrators or their legal representative any and all such personal health information necessary for benefit determination, payment, treatment or plan operations.

I further authorize Custom Benefit Administrators to pay benefits directly to the provider unless otherwise indicated at the time of claim submission.

Any information obtained will not be released by Custom Benefit Administrators to any person or organization except to reinsuring companies, or any other persons or organizations performing business or legal services in connection with my application, the processing of claims or as may be otherwise lawfully required. For more information on possible release of information, I can contact Custom Benefit Administrators for a copy of their privacy policy. I will be notified of any subsequent changes to that policy.

I know that I may request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization is valid for two years from the signature date. Authorization may be revoked by written request.

I hereby certify that all the information shown above is true and correct to the best of my knowledge. I also understand that any false information listed will null and void this application and the coverage for which it applies. The plan reserves the right to rescind coverage should the above information prove not to be complete or accurate.

Signature of Employee (Required) **Date Signed** (OVER)

St. Ambrose Financial Services, Inc. - P.O. Box 4004 - La Crosse, WI 54602-4004 - (608) 791-2669

NOTE: Legally, the "Notice of Special Enrollment Period Rights" MUST be attached to this Group Enrollment Form.

OTHER IMPORTANT PLAN INFORMATION

Notice of Enrollment Rights:

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. My spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with a marriage or the birth adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption or placement for adoption. Application to add a new dependent must be made within 31 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to Custom Benefit Administrators (CBA) or your employer within 31 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to CBA or your employer within 30 days of the marriage, birth, adoption or placement for adoption.

You may also apply for coverage for you and any eligible dependent during the open enrollment period each year in August.

If you have any questions, you may contact Custom Benefit Administrators at 1-800-944-2188.

Eligibility and Effective Date of Coverage:

For newly hired employees, coverage is effective the first of the month following employment in a benefit eligible position.

Age Limits for Dependent Children:

Coverage for eligible children will cease at the end of the month in which the child reaches the age of 26.