Employer Information

Employer Name (Parish - School - Institution)

DOL Location #

Diocese of La Crosse
Lay Benefits
Employer & Participant Information
New Enrollment

Group # L06588

SAFS Use Only - Effective Date

Participant Information

First Name | **Last Name** | **MI** | **Phone Number** | **Social Security Number**

Street Address | **City** | **State** | **Zip** | **Personal Email**

Birth Date | Male Female | Single Married | Full Time Year-Round | Part Time Year-Round | Full Time School-Year | Part Time School-Year | **Job Title** | **First Day Of Work** | **Hours Per Week**

Benefit Elections

Please Select One From Each Election. If you Waive Medical, Skip Plan Selection

Medical: Single | Family | Waive

Plan: Traditional | High Deductible HSA | "The Max" HSA

Vision *Included With Medical*: Single | Family | Waive

Dental: Single | Single+1 | Family | Waive

Dependents

Spouse Or Child	First Name	Last Name	MI	Social Security Number	Birth Date	Male	Female	Medical	Vision	Dental

Other Insurance Coverage

As of your effective date, will there be any other insurance in effect for you or any dependents listed above? If Yes, Please Complete Below

Primary Insured	Medical Carrier	Policy - Group Number	Effective Date	Single	Family	Vision	Dental

Dependents Covered - First & Last Name - One Dependent Per Box

Medical Release - Acceptance - Authorization

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true.

To verify incorrect information on 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 (if any) to the cost of the benefits I have selected.

If I am declining enrollment for myself or my dependents 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 the other coverage ends.

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 that event.

I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans.

By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have a qualifying event or family status change.

Participant Signature - Required

Date

Basic Life *Accidental Death/Dismemberment*

Participant Must Elect This Benefit OR Waive At The Start Of Employment. Election AFTER the original employment window is NOT Guaranteed. An Evidence Of Insurability Will Be Requested To Enroll In Basic Life And Be Determined by The Hartford Insurance Group

☐ Elect ☐ Waive

Beneficiary

First & Last Name	Address	City	State	Zip

E-Mail	Phone Number	Relationship	DOB	SSN

Contingent Beneficiary

First & Last Name	Address	City	State	Zip

E-Mail	Phone Number	Relationship	DOB	SSN

Participant Signature **Date**

Spousal Consent

Community Property State Consent for Wisconsin Residents

If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in this benefit.

As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.

Spouse Signature Date