DIOCESE OF LA CROSSE PRIESTS BENEFITS ENROLLMENT & CHANGE FORM

Anthem

SAFS Use Only - Effective Date: _____

PARISH/INSTITUTION _____ City _____ # _____ Group # L06588

PRIEST INFO

Last Name _____ First Name _____ MI _____ Birth Date _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

[X] Single

[X] Male

Job Title _____ First Date of Class / Eligible Status _____ Personal Email _____ Phone Number _____

PURPOSE OF FORM *(Must mark one box)*:

[ ] NEW ENROLLMENT

[ ] CHANGE

- [ ] Termination / Resignation — Last Day of Eligibility _____
- [ ] Address – provide new address under priest info
- [ ] Other – personal email, phone number, etc.
- [ ] Qualifying Event _____

State the Qualifying Date and the Qualifying Event - - *(Loss of Coverage / Newly Eligible / Etc.)*

MEDICAL / VISION / DENTAL ELECTION - *Select Individual for coverage or select WAIVE*

Medical		Vision		Dental	
Traditional Deductible Plan	[ ] Individual	Included w/Medical	[ ] Individual		[ ] Individual
	[ ] Waive		[ ] Waive		[ ] Waive

OTHER INSURANCE COVERAGE

As of your effective date, will there be any other insurance in effect on you? [ ] No [ ] Yes

If Yes, Primary Insured Name _____ Carrier _____ Group/Policy # _____ Effective Date _____

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 I may, in the future, be able to enroll in this plan. I must request enrollment within 31 days after the other coverage ends.

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, and Dental 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 qualifying event or family status change.

_____ _____

Enrollee Signature** (Required)* ***Date

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