Archdiocese of
LOS ANGELES

132 Ivy Lane
King of Prussia, PA 19406
Phone: (877) 303-7382
Fax: (877) 332-7382

# 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.

❒ New Enrollment ❒ Waiver ❒Change ❒Transfer from Location #_____ to #_____ ❒Terminate

| Location Name | Location Number | Phone Number |
|---|---|---|
| | | |

**I. EMPLOYEE INFORMATION** ❒Lay ❒Religious ❒Priest ❒Part-Time

| Date of Hire | Date Full Time | Effective Date | Date of Birth | Annual Salary $_____ Paid in 10 or 12 Months? | Hours Worked / Week | Marital Status | Date of Marriage |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Last Name | First | MI | Soc. Sec. No. | Sex (M/F) |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip | Home Phone (including area code) ( ) |
|---|---|---|---|---|
| | | | | |

| E-Mail | Work Phone (including area code) ( ) |
|---|---|
| | |

**II. COVERAGE ELECTION** (complete dependent information section if coverage elected for spouse and/or children)
**DEPENDENTS ELECTING COVERAGE MUST ENROLL IN THE SAME MEDICAL/VISION OR DENTAL PLANS AS THE EMPLOYEE.**

| Coverage | Effective Date | Employee | Spouse | Child(ren) | Add/Term | Comments |
|---|---|---|---|---|---|---|
| Blue Cross PPO | | ❒Yes ❒No | ❒Yes ❒No | ❒Yes ❒No | | |
| Blue Cross EPO | | ❒Yes ❒No | ❒Yes ❒No | ❒Yes ❒No | | |
| Kaiser EPO | | ❒Yes ❒No | ❒Yes ❒No | ❒Yes ❒No | | |
| Dental | | ❒Yes ❒No | ❒Yes ❒No | ❒Yes ❒No | | |
| Voluntary Short Term Disability | | ❒Yes ❒No | **You may elect Voluntary Short-Term Disability (STD) or Voluntary Long-Term Disability (LTD), but not both** | | | |
| Voluntary Long Term Disability | | ❒Yes ❒No | | | | |
| Voluntary Life AD&D | | ❒Yes ❒No | Check One ❒1x Base Salary ❒1.5x Base Salary ❒ 2x Base Salary | | | |

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

| Name | SSN | Relationship | Sex (M/F) | DOB | Dependent Certification Attached | Add/Term (A/T) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**IV. BENEFICIARY INFORMATION** (Complete if Enrolling in Voluntary Life/AD&D Program. Please Note: If you are electing a beneficiary to your life insurance other than your spouse, your spouse must sign the spousal consent in the beneficiary form.)

| Name | Relationship | Date of Birth | Primary/Contingent | % Breakdown |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**V. WAIVER** (Signature is required if any benefit is waived)
The current benefits have been explained to me thoroughly. I DO NOT wish to enroll in the following coverage(s).

❒Employee ❒ Medical / Vision ❒ Dental ❒ Voluntary Life AD&D ❒ Voluntary Short Term Disability ❒ Voluntary Long Term Disability
❒Employee and/or Dependent ❒ Medical / Vision ❒ Dental

Is the coverage being waived due to coverage by another plan? ❒Yes ❒No I understand that by waiving the coverage above, I will not be entitled to any benefits provided by the plan.

SIGNATURE X_____ Date_____
(To Waive Benefits)

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**VI. RELEASE**

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 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 any claim of 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.

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

**SIGNATURE X**_____ **Date**_____
(Required)

**TO BE COMPLETED BY LOCATION ADMINISTRATOR ONLY**

**VII. REASON FOR THE CANCELLATION / CHANGE**

**EMPLOYEE COVERAGE:**

❒ Discharged
❒ Retirement
❒ Reduction in work hours: Date_____
❒ Deceased: Date_____
❒ Date of Disability _____
❒ Resignation: Date Submitted:_____
❒ Last day worked:_____
❒ New Address
❒ New Dependent
❒ Increase in work hours: Date _____
❒ New name: _____
❒ Other please specify: _____

**DEPENDENT COVERAGE:**

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

| Name of person completing this section (Please Print) | Signature | Date |
|---|---|---|
| | | |