Archdiocese of New Orleans, Group Number: 76-413717

ARCHDIOCESE OF NEW ORLEANS

2018/2019 BENEFIT ENROLLMENT/CHANGE FORM

Subgroup Number: _____ **Subgroup Name:**_____

Effective Date of Enrollment /Change: _____

ENROLLMENT:	CHANGE:	TERMINATION DATE: _____
☐ Annual Enrollment ☐ New Staff Member ☐ Rehired/Reinstatement	☐ Add/Remove Dependent ☐ Name Change ☐ Location Transfer from:_____ to: _____ ☐ Address Change ☐ "Family Status" Change ☐ Retiring: move from Class: _____ to Class: R001 ☐ Product Change from: _____ to: _____	☐ Termination of Employment ☐ Death ☐ Layoff/Leave of Absence

SECTION A: STAFF MEMBER PERSONAL INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____ **SOCIAL SECURITY NO:** _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____ **HOME TELEPHONE:** _____ **CELL PHONE:** _____

DATE OF HIRE: _____ **GENDER:** ☐ FEMALE ☐ MALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED

SECTION B: MEDICAL BENEFIT PLANS - UMR | UNITED HEALTHCARE CHOICEPLUS NETWORK

☐ **CHECK HERE IF YOU ARE DECLINING MEDICAL COVERAGE**

I DECLINE TO ENROLL IN THIS COVERAGE DUE TO: ☐ Spouse's Group Employer Plan: Plan Name:_____; Policy Number: _____ ☐ Tri-Care ☐ Individual Plan ☐ Other:_____
☐ COBRA or other continuation coverage from Prior Employer ☐ Medicare ☐ Medicaid ☐ Retiree from Prior Employer ☐ VA Eligibility

MEDICAL PLAN 1 - HMO 90		MEDICAL PLAN 2 - POS		MEDICAL PLAN 3 - HIGH DEDUCTIBLE HMO 80		MEDICAL PLAN 4 - OUT OF AREA PPO PLAN	
(CHECK ONE)		(CHECK ONE)		(CHECK ONE)		(CHECK ONE)	
EE ONLY	☐	EE ONLY	☐	EE ONLY	☐	EE ONLY	☐
EE + SPOUSE	☐	EE + SPOUSE	☐	EE + SPOUSE	☐	EE + SPOUSE	☐
EE + CHILD(REN)	☐	EE + CHILD(REN)	☐	EE + CHILD(REN)	☐	EE + CHILD(REN)	☐
EE + FAMILY	☐	EE + FAMILY	☐	EE + FAMILY	☐	EE + FAMILY	☐

SECTION C: OTHER COVERAGE

Medical Plans: Dependent children are covered to age 26 regardless of student status.
Other Coverage Information: Will you or your dependents that you are enrolling in the plan have any other medical coverage in addition to this plan? ☐ Yes ☐ No
If yes, Please indicate carrier information:

Carrier Name:	Policy Number:	Group #	Coverage Start Date:	Coverage End Date:	Are you enrolled in Medicare?	☐ Yes	☐ No
					Medicare # _____	☐ Part A	☐ Part B

SECTION D: ELIGIBLE DEPENDENTS FOR MEDICAL PLANS (COMPLETE ONLY IF DEPENDENT COVERAGE IS ELECTED)

DEPENDENT NAMES (FULL NAME)	SSN	GENDER (Circle One)	DATE OF BIRTH	RELATIONSHIP	MEDICAL ADD/CANCEL Add/Cancel	
SPOUSE:		M / F			☐ Add	☐ Cancel
CHILD 1:		M / F			☐ Add	☐ Cancel
CHILD 2:		M / F			☐ Add	☐ Cancel
CHILD 3:		M / F			☐ Add	☐ Cancel
CHILD 4:		M / F			☐ Add	☐ Cancel
CHILD 5:		M / F			☐ Add	☐ Cancel

HIPAA: If you are declining enrollment for yourself or your dependents because you have other group health coverage, you may in the future be able to enroll yourself and your dependents (Qualifying Event), provided that you request enrollment withing 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

See Other Side for Qualifying Events and Employee Acknowledgement

Employee Last Name:_____ **Employee First Name:** _____ **Subscriber #:**_____

SECTION E: QUALIFYING LIFE EVENT DATE:_____

☐ Marriage	☐ Placement for Adoption	If you lost coverage due to: (please complete Section C)	☐ Divorce	☐ Other:_____
☐ Birth	☐ Provisional Custody by Mandate		☐ Death	☐ COBRA or other continuation exhausted
☐ Adoption	☐ Qualified Medical Child Support Orc		☐ Termination or reduction in work hours	

SECTION F: STAFF MEMBER ACKNOWLEDGEMENT AND PREMIUM ONLY AUTHORIZATION - (AUTHORIZING DEDUCTIONS TO BE TAKEN ON A PRE-TAX BASIS)

I HEREBY UNDERSTAND THAT A SALARY REDUCTION FOR MEDICAL CONTRIBUTION PREMIUMS WILL BE TAKEN ON A PRE-TAX BASIS. I UNDERSTAND THAT THIS ELECTION CANNOT BE REVOKED DURING THE PLAN YEAR UNLESS THERE IS A QUALIFYING EVENT.

1.I, the undersigned, do hereby enroll for coverage with UMR, a UnitedHealthcare Company, for myself and any family members listed on this enrollment form.
I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made an intentional misrepresentation of material fact in this enrollment/change form. I further understand that if enrolled for coverage with UMR, a UnitedHealthcare Company, that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that UMR, a UnitedHealthcare Company, are all independent corporations operating under a license from the UMR Association, an association of independent UMR plans, the "Association" permitting the individual companies to use the UMR service marks in the state of Louisiana and that the companies are not contracting as an agent of the Association.

2. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be necessary. The information given on this application is true and correct to the best of my knowledge and belief.
3. I understand that if I am declining enrollment for myself or my Dependents (including spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. In addition, if I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my Dependents provided that I request enrollment within 30 days after the marriage, birth adoption or placement for adoption.
4. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance For People With Medicare."
5. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.
6. FRAUD STATEMENT - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
7. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or Dependent(s) if any, are true and correct to the best of my knowledge and belief.

_____ _____

Employee Acknowledgement (Signature Required) **Date:**